

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23001

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

CHARLES ALLEN HAMMOND

2. Date of Death

July 18, 2000

3. Time of Death

1135pm

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

212-36-9030

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 06, 1942

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

827 ARLINGTON AVENUE

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LONG SHOREMAN

16b. Kind of Business/Industry

STEAMSHIP TRADE

17. Father's Name (First, Middle, Last)

AMOS

BRAUN

MARY

HAMMOND

19a. Informant's Name/Relationship (Type, Print)

JOAN WILLIAMS (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2103 BROOKFIELD AVE., BALTO., MD. 21217

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS CEMETERY

Date

7-22-00

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
3140 N. FULTON AVE., BALTO., MD. 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Cerebrovascular Accident

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ OOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J Gong MD

29c. License number

89372

29d. Date signed (Month, Day, Year)

7/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jinhui Gong, M.D. 90 Maryland General Hospital

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

*[Signature]*

State Registrar

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410.363.0000.

Charles Hammond





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23002

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSS JAMES HILL</b>				2. Date of Death Month <b>JULY</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>7:55 AM</b>
	4a. Facility Name (If not Institution, give street and number) <b>GOOD SAMARITAN HOSPITAL 5601 LOCHRAVEN BLVD.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>215-18-8968</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10/13/1922</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>37 Greenwood Avenue</b>			10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Millwright</b>		16b. Kind of Business/Industry <b>Steel</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Walter Amos Hill</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Drilling</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>David Gerstmyer</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4626 Greenhill Avenue Baltimore, Maryland 21206</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>MOOSE</b>			22. Name and Address of Facility <b>John C. Miller Inc.</b> <b>6415 Belair Road Baltimore, Maryland 21206</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>CARDIOGENIC SHOCK</b>						
	Due to (or as a consequence of): <b>ACUTE MYOCARDIAL INFARCTION.</b>						
	Due to (or as a consequence of):						
Due to (or as a consequence of):							
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Katrina Marx</i> <b>PGY-2</b>					
		29c. License number <b>P 13965</b>		29d. Date signed (Month, Day, Year) <b>JULY 14 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GOOD SAMARITAN HOSPITAL 5601 LOCHRAVEN BLVD. BALTIMORE MD. 21236.</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23003

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Regina L. Holmes

2. Date of Death

Month Day Year  
July 17 2000 6:43 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Mercy Hosp

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N.A.

5. Social Security Number

213 32 1483

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)  
Oct 13, 1934

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

N.A.

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5000 Crenshaw Ave apt D.

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

St. Vincent De Paul

17. Father's Name (First, Middle, Last)

Earl Jones

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Hackman

19a. Informant's Name/Relationship (Type, Print)

Barbara Stokes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1330 Pentwood Rd Baltimore, Md 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Calvary Cem.

Date

7/22/00

20c. Location - City or Town, State

A.A. County Md.

21. Signature of Funeral Service Licensee

Joseph B. Locke Jr.

22. Name and Address of Facility

Joseph B. Locke Jr. 3/4 1304h Central Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Insufficiency  
Hepatic Encephalopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Stella Maris at Mercy Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Riseberg

29c. License number

D 40854

29d. Date signed (Month, Day, Year)

July 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23004

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS HARVEY

2. Date of Death

Month Day Year  
JULY 9, 2000

3. Time of Death

7:35 PM

4a. Facility Name (If not institution, give street and number)

SOUTHERN MD HOSPITAL CENTER

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-52-0604

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 15, 1939

9. Birthplace (State or Foreign Country)

unk

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9211 Stuarts Lane

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

unk

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: unk

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Southern MD Hospital Center

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

70533 Sarates Road Clinton, MD 20735

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *left lung extensive Pneumonia* Due to (or as a consequence of):

1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Schizophrenia* Due to (or as a consequence of):

5 yr

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

J. B. Van Sant, M.D. Attending

29c. License number

D-24535

29d. Date signed (Month, Day, Year)

07.11.00

30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)

LAXMITA B. GRYAL, SOUTHERN MD HOSPITAL CENTER

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

[Signature]

33. Registrar's Title

Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
20258.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





00-3928-510

ROSALINE

HACKERMAN

amend item 22 per fh G785 7/20/00 yg

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23005

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerState  
Registrar

1. Decedent's Name (First, Middle, Last) <b>ROSALIND HACKERMAN</b>		2. Date of Death Month <b>JULY</b> Day <b>16</b> Year <b>2000</b>		3. Time of Death <b>7:08P.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>3410 BELAIR ROAD</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>213-58-1773</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>NOV. 17, 1952</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>3410 BELAIR ROAD</b>			10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>Waitress</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WAITRESS</b>		16b. Kind of Business/Industry <b>RESTAURANT</b>
17. Father's Name (First, Middle, Last) <b>SANGWILL</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>JEANNETTE MOFFET</b>		
19a. Informant's Name/Relationship (Type, Print) <b>JEANNETTE HACKERMAN / MOTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3601 FORDS LANE #601 - BALTIMORE, MD 21215</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TAMID LUBAWITZ NUSACH ARI (NER</b>		20c. Location - City or Town, State <b>ROSEDALE, MD</b>	
21. Signature of Funeral Service Licensee <i>Scott M. Cutler</i>		22. Name and Address of Facility <b>Sol Levinson &amp; Bros., Inc. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cirrhosis of Liver</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Theodore M. King</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature <i>Benita Sparks</i>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23006

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MYRTIE JOHNSON

2. Date of Death

07-12-2000

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

LORIAN NURSING HOME

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

218-18-9561

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-20-13

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3600 W. FRANKLIN STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 TH GRADE

College (1-4 or 5+)

2 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LIBRARY AIDE

16b. Kind of Business/Industry

UNIVERSITY OF MD

17. Father's Name (First, Middle, Last)

SAMUEL TAYLOR

18. Mother's Name (First, Middle, Maiden Surname)

VERTIE RANDALL

19a. Informant's Name/Relationship (Type, Print)

ELLIOTT YOUNG / NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8775 ROSE LANE, JESSUP, MD. 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

1-18-00 OWINGS MILLS, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vaughn C H

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE  
5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Parkinson's Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marshall Freedman D.O.

29c. License number

H37211

29d. Date signed (Month, Day, Year)

JULY 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARSHALL FREEDMAN, D.O. 2 KNOLL, COLUMBIA, MD 21045

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

Benjamin S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit




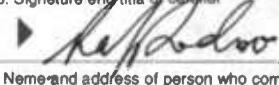
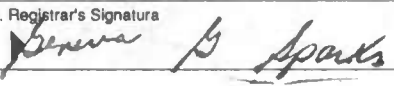
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23007

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH JONES</b>				2. Date of Death Month Day Year <b>July 18 2000</b>		3. Time of Death <b>1100PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSP 5601 Loch Raven BLVD</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>250-30-0571</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JULY 25, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>		10a. State <b>MARYLAND</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4700 HARTFORD ROAD</b>		10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>USA.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3RD GRADE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>SCARLET SEED</b>		17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>CARRIE JONES</b>		19a. Informant's Name/Relationship (Type, Print) <b>SANDRA FARMER (GRANDDAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3140 CLIFTMONT AVE. BALTIMORE, MD. 21213</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD. NATIONAL CEMETERY 7-25-00</b>		20c. Location - City or Town, State <b>LAUREL, MARYLAND</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b. CARDIOGENIC SHOCK</b> Due to (or as a consequence of): <b>c. ESRD</b> Due to (or as a consequence of): <b>d.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was cause related to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? 1 Yes 2 No</b> <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and Title of certifier  MD		29c. License number <b>P12557</b>		29d. Date signed (Month, Day, Year) <b>JULY 18, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAPHAEL DODOO, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239</b>		31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



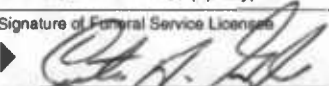


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State of Maryland / Department of Health and Mental Hygiene 00 23008

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lawrence Peter Jagodzinski</b>				2. Date of Death Month <b>7-</b> Day <b>18-</b> Year <b>00</b>		3. Time of Death <b>3:00 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3509 Joppa Road</b>				4b. City, Town, or Location of Death <b>Parkville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-24-3737</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 16, 1929</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3509 Joppa Road</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th. Grade</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Auto Manufacturer</b>		17. Father's Name (First, Middle, Last) <b>August William Jagodzinski</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Mary Serba</b>		19a. Informant's Name/Relationship (Type, Print) <b>J. Garry Jagodzinski/ Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>912 Southwick Road Baltimore MD 21286</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Cross Polish National</b>		20c. Location - City or Town, State <b>Baltimore MD</b>		20d. Date <b>07/21/2000</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>Dippel Funeral Home, Inc. 6415 Belair Road Baltimore MD 21206</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic non small cell lung cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		Approximate Interval Between Onset and Death <b>7 months</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>July 19, 2000</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 		29c. License number <b>D45530</b>		29d. Date signed (Month, Day, Year) <b>July 19, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. SIUVASILAM, 6830 Hospital Drive, Suite 206, MD-21237</b>		
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature 		State Registrar		Division of Vital Records, P.O. Box 68760,		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23009

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Floyd Jackson				2. Date of Death Month Day Year July 19, 2000				3. Time of Death 5:00 am	
	4a. Facility Name (If not institution, give street and number) 1470 Reynolds Street				4b. City, Town, or Location of Death Baltimore City				4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-05-5265		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Sept. 9, 1914		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1470 Reynolds Street		10f. Zip Code 21230		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipyard Worker		16b. Kind of Business/Industry Steel Industry					
	17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Middle, Maiden Surname) Unknown		19a. Informant's Name/Relationship (Type, Print) Donald Jackson / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1470 Reynolds Street, Baltimore Maryland 21230			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		Date July 22, 2000		20c. Location - City or Town, State Baltimore Maryland			
	21. Signature of Funeral Service Licensee Victor P. Doda, Jr.		22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiomyopathy Due to (or as a consequence of) b. Myelodysplasia Due to (or as a consequence of) c. Pancytopenia Due to (or as a consequence of) d. prostate cancer.						Approximate Interval Between Onset and Death 2 years 2 years			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier G. N. M. MAGALDA		29c. License number D 39041		29d. Date signed (Month, Day, Year) July, 19 <sup>th</sup> 2000					
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Harbor Hospital center 3001 S. Hanover street Baltimore									
	31. Date filed (Month, Day, Year) JUL 20 2000		32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23010

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY L. KNIGHT

2. Date of Death

JULY 17, 2000

3. Time of Death

2056

4a. Facility Name (If not institution, give street and number)

ST. AGNES HEALTHCARE

900 CATON AVENUE

BALTIMORE

4b. City, Town, or Location of Death

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-60-7231

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

10-19-52

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4100 COLBOURNE ROAD

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 TH GRADE

College (1-4 or 5+)

1 YR.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FACTORY WORKER

16b. Kind of Business/Industry

POLY SEAL CORP.

17. Father's Name (First, Middle, Last)

SYLVESTER WHITE

18. Mother's Name (First, Middle, Maiden Surname)

WILLIE MAE HOLLY

19a. Informant's Name/Relationship (Type, Print)

KAREN JENKINS / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3435 EDMONDSON AVE. BALTO. MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

7-22-00

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

Vaughn C. H.

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE  
5151 BALTO NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Brain cancer

Due to (or as a consequence of):

1 year

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

metastatic Breast cancer

Brain metastasis, Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. S. - MD

29c. License number

B65848996

29d. Date signed (Month, Day, Year)

JULY 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Greenwald MD 900 Caton Avenue St Agnes Hospital

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

Brenda A. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

12-10-1911  
12-10-1911

12-10-1911  
12-10-1911  
12-10-1911

12-10-1911



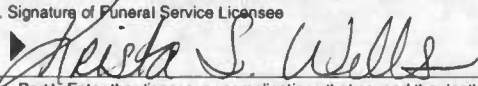

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23011

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Karl E.A. Kraft				2. Date of Death July 13, 2000 Year				3. Time of Death 4:22pm						
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore City				4c. County of Death						
Funeral Director	5. Social Security Number 217-16-3975		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) Feb 12, 1922		9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville						
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2626 Wendover Rd.		10f. Zip Code 21234		10g. Citizen of What Country? UUSA								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief engineer		16b. Kind of Business/Industry Borden Ice Cream								
	17. Father's Name (First, Middle, Last) Karl A.E. Kraft				18. Mother's Name (First, Middle, Maiden Surname) Agnes M. Sacks										
	19a. Informant's Name/Relationship (Type, Print) Margaret Grace Kraft				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2626 Wendover Rd., Parkville, MD 21234										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial		Date Jul 17 2000		20c. Location - City or Town, State Timonium, MD								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Parkville, MD										
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>PNEUMONITIS</u> Due to (or as a consequence of): b. <u>MICROANGITIS VASCULITIS</u> Due to (or as a consequence of): c. <u>INTERSTITIAL PULMONARY FIBROSIS</u> Due to (or as a consequence of): d. <u>RENAL FAILURE</u>										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier  Ralene Mair		29c. License number PC74-2 P13965		29d. Date signed (Month, Day, Year) JULY 13 <sup>th</sup> 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE, MD. 21236															
31. Date filed (Month, Day, Year) JUL 20 2000		32. Registrar's Signature 													
State Registrar															

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23012

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gordon C. Kirby, Sr.

2. Date of Death

Month Day Year  
JULY, 18, 2000

3. Time of Death

9:57 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-12-8639

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 30, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1644 Gleneagle Road

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4or 5+)

18e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)  
Steel Worker

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Arthur Kirby

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Howard

19a. Informant's Name/Relationship (Type, Print)

Mr. Gordon Kirby, JR. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1644 Gleneagle Road Baltimore, Maryland 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill

Date

7/22/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PULMONARY EMBOLISM

Approximate Interval Between Onset and Death

7 HOUR

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SP CABG, EMPHYSEMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Puthumana MD

29c. License number

D47123

29d. Date signed (Month, Day, Year)

JULY 18, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. PUTHUMANA, UNION MEM. HOSP. BALTIMORE MD 21218

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

James S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Gordon C. Kirby  
Division of Vital Records, P.O. Box 68760,  
6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23013

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT G. LINA</b>				2. Date of Death Month Day Year <b>JULY 15, 2000</b>				3. Time of Death <b>8:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3415 FOSTER AVE.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-26-3101</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 6, 1930</b>		9. Birthplace (State or Foreign Country) <b>PA.</b>	
	Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3415 FOSTER AVE.</b>				10f. Zip Code <b>21224</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH</b> Collage (1-4or 5+) <b>Collage</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOREMAN</b>				16b. Kind of Business/Industry <b>STEEL</b>		
17. Father's Name (First, Middle, Last) <b>FRANK LINA, SR.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN BAUMAN</b>					
19. Informant's Name/Relationship (Type, Print) <b>ELIZABETH C. LINA/WIFE</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3415 FOSTER AVE., BALTIMORE, MD. 21224</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OAK LAWN CEMETERY</b>			20c. Location - City or Town, State <b>7/18/00 BALTIMORE, MD.</b>				
21. Signature of Funeral Service Licensee <i>Elizabeth A. Schenke</i>					22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224</b>					
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Esophageal Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>2 years</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Dr. A. H. M.</i>					29c. License number <b>D40854</b>		29d. Date signed (Month, Day, Year) <b>7/19/00</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dan Roseberg 301 St Paul Pl Baltimore, MD 21202</b>										
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G789 7-21-00 WR

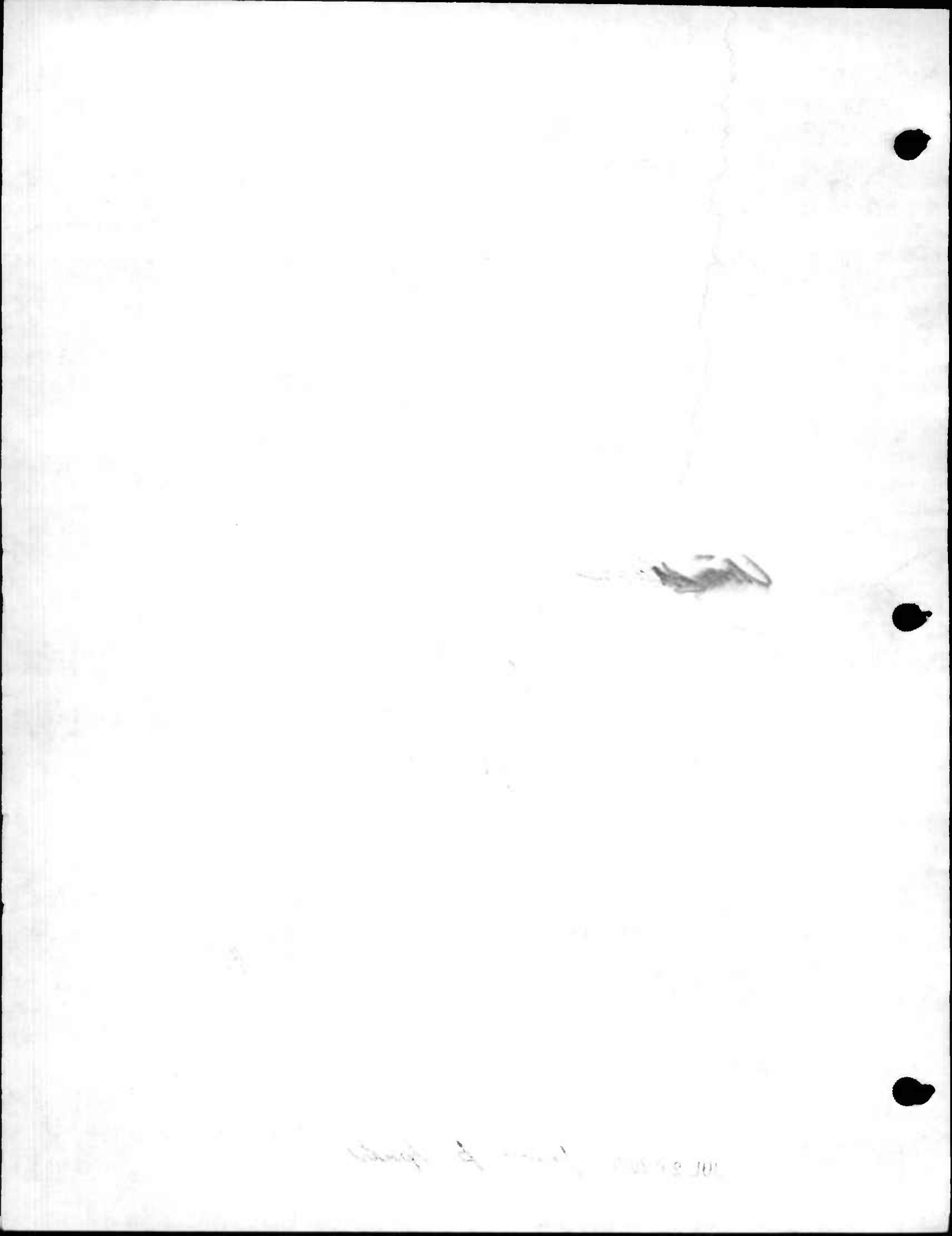
Certificate of Death

Reg. No.

00 23014

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Michael Andrew Logan</b>				2. Date of Death Month Day Year <b>July 11 2000</b>		3. Time of Death <b>9:15 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Port Tobacco Marina</b>				4b. City, Town, or Location of Death <b>Port Tobacco</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>223-06-4462</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>39</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 1, 1960</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>VA</b>		10b. County		10c. City, Town or Location	
To Be Completed by Funeral Director	10a. Street and Number <b>2263 Brook Road</b>				10f. Zip Code <b>22554</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Construction</b>			
	17. Father's Name (First, Middle, Last) <b>Donald F. Logan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marcia Niebrand</b>			
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) <b>Donald F. Logan</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>636 Brushwood Court Greenwood, IN 46142</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sterling Cemetery</b>		20c. Location - City or Town, State <b>7-14-00 Sterling, VA</b>		20d. Date	
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Adams-Green Funeral Home</b> <b>721 Elden Street Herndon, VA 20170</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>DROWNING</b>				Approximate Interval Between Onset and Death			
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <b>DROWNING</b>				Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DROWNING</b>				Due to (or as a consequence of):			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found: 7-11-00</b>		28b. Time of Injury <b>8:05</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred <b>SUBJECT DROWNED</b>				28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>POTOMAC RIVER, POPES CREEK, CHARLES COUNTY, MD</b>			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
To Be Completed by Physician/Medical Examiner	29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>July 12, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 				33. Date of Death (Month, Day, Year) <b>JUL 11 2000</b>			
	34. State Registrar <b>MDHM 16 Rev 6/95</b>				35. Original			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23015

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRIETT

2. Date of Death

Month Day Year  
JULY 14 2000

3. Time of Death

1055

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral  
Director

5. Social Security Number

213-32-4888

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08-07-37

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5204 Hazelwood Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory worker

16b. Kind of Business/Industry

Columbia Molding

17. Father's Name (First, Middle, Last)

William C. Mosley, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Williams

19a. Informant's Name/Relationship (Type, Print)

William Mosley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5204 Hazelwood Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Mem. Gardens 07-22-00 Dundalk, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer  
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

4 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS LIU, JOHNS HOPKINS HOSPITAL, TOWER 110, BALTIMORE, MD 21287

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Page 1 of 1  
Date: 1-1-1968

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

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State of Maryland / Department of Health and Mental Hygiene

amend item 22 per fh G785 7/20/00 yg

Certificate of Death

Reg. No.

00 23016

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NELLIE</b>		2. Date of Death Month Day Year <b>JULY 17, 2000</b>		3. Time of Death <b>1:55 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>JEWISH CONVALESCENT &amp; NURSING HOME</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>167-16-3328</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>101</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JULY 19, 1898</b>		9. Birthplace (State or Foreign Country) <b>GERMANY</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>STEVENSON</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>10600 CANDLEWICK ROAD</b>		10f. Zip Code <b>21153</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
17. Father's Name (First, Middle, Last) <b>ELIAS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>KLING MINA WEIL</b>			
19a. Informant's Name/Relationship (Type, Print) <b>WERNER S. STRAUSS / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10600 CANDLEWICK ROAD - STEVENSON, MD 21153</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MONTEFIORE CEMETERY</b>		20c. Location - City or Town, State <b>7/19/00 ABINGTON TOWNSHIP, PA</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebral Hemorrhage</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. IMMEDIATE</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>			
29c. License number <b>115140</b>		29d. Date signed (Month, Day, Year) <b>July 17, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>IAN SIMONE, MD 6210 Keltus Ave, Baltimore, MD 21215</b>					
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23017

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ellen Nethen

2. Date of Death

Month Day Year  
JULY 19, 2000

3. Time of Death

5:40 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

233-42-2233

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 2 1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2302 Shoreham Ct. Apt. F

10f. Zip Code

21015

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Employee

16b. Kind of Business/Industry

Dept.  
Harford Co. Sheriff

17. Father's Name (First, Middle, Last)

Thomas Gathercole

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Cupp

19a. Informant's Name/Relationship (Type, Print)

John A. Nethen Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2302 Shoreham Ct. Apt. F Bel Air, MD 21015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

All County Cremation, Inc. 7/20/2000 Sykesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.  
1212 W. Old Liberty Road Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ACUTE MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

1 HOUR

a. Due to (or as a consequence of):

CORONARY ATHEROSCLEROSIS

YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 17695

29d. Date signed (Month, Day, Year)

JULY 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH S. HELOU, M.D., 7601 OSLER DR., TOWSON, MARYLAND 21204

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #14 PER FH G785 7/20/00 AH

## Certificate of Death

Reg. No.

00 23018

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marion Curtin Price

2. Date of Death

Month  
July

Day

15

Year

2000

3. Time of Death

6:02 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

222-24-9028

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

5-11-1937

9. Birthplace (State or Foreign Country)

Pa

Usual Residence of Decedent

10e. State

Md

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3829 Kilburn Road

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify: ~~Black~~ WHITE15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th gradeCollege (1-4 or 5+)  
NA16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

NA

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

George Y. Price

18. Mother's Name (First, Middle, Maiden Surname)

Louise Dorsey Leathers

19a. Informant's Name/Relationship (Type, Print)

Gloria Bristol-Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3829 Kilburn Road Randallstown, Md 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt Zion Cemetery

Date

7-20-00

20c. Location - City or Town, State

Lansdown, Md

21. Signature of Funeral Service Licenses

Jerome A. Simpson

22. Name and Address of Facility

March F. H. West

4300 Wabash Avenue Balto, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Bronchopneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Wound Sepsis

Due to (or as a consequence of):

10

c. ARDS Syndrome

Due to (or as a consequence of):

10

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Primary Peritoneal Tumor

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Helen Z. Norwood, M.D.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

July 15, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Helen Z. Norwood, M.D. 2401 West Belvedere Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

Benjamin S. Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23019

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIAN BEATRICE PINEAU</b>				2. Date of Death Month Day Year <b>JULY 19, 2000</b>				3. Time of Death <b>12:38 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>				4c. County of Death <b>BALTIMORE</b>			
Funeral Director	5. Social Security Number <b>219-58-0422</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 13, 1914</b>		9. Birthplace (State or Foreign Country) <b>New York</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>107-C Versailles Circle</b>				10f. Zip Code <b>21204</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Edward William Pineau</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Victoria Monsion</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Susan Dimling (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>706 Stevenson Lane Baltimore, Maryland 21286</b>							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corporation</b>				20c. Location - City or Town, State <b>7-21-2000 Towson, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>George J. Ferrante</b>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	e. <b>CEREBRAL THROMBOSIS</b> Due to (or as a consequence of):										<b>Four days</b>	
	b. <b>CARDIOMYOPATHY</b> Due to (or as a consequence of):										<b>5 years</b>	
	c. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):										<b>20 years</b>	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
											24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
State Registrar	29b. Signature and title of certifier <b>David E. Kaplan MD</b>				29c. License number <b>00055583</b>				29d. Date signed (Month, Day, Year) <b>July 19, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID E. KAPLAN, MD; GBMC HOSPITALISTS; 6704 N. CHARLES ST. BALTIMORE, MD 21204</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature <b>[Signature]</b>									

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23020

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jackie Robertson</b>				2. Date of Death Month <b>07</b> Day <b>14</b> Year <b>00</b>		3. Time of Death <b>2130</b>	
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical System</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>219-666-7739</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>45</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-19-54</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3066 MAYFIELD AVENUE</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH GRADE</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>BALTIMORE CITY</b>		17. Father's Name (First, Middle, Last) <b>JAME A. MILLS</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>LIZZIE ROBERTSON</b>		19a. Informant's Name/Relationship (Type, Print) <b>THERESA LOVINGS SISTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3066 MAYFIELD AVE., BALTO. MD. 21213</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Date <b>7-19-00</b>		20d. Location - City or Town, State <b>BALTO. MD</b>		21. Signature of Funeral Service Licensee <b>Daugh C H</b>		
22. Name and Address of Facility <b>CREMATION SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hila-failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Pneumocystis Carinii pneumonia</b> Due to (or as a consequence of): b. <b>HIV / AIDS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		
28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Sanbula MD</b>		29c. License number <b>P13115</b>		
29d. Date signed (Month, Day, Year) <b>7/14/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>22 S. Greene St. Baltimore, MD 21201</b>		31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature <b>Bernard G Sparks</b>		

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23021

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Louise Riddle</b>				2. Date of Death Month <b>July</b> Day <b>12</b> Year <b>2000</b>				3. Time of Death <b>19:52</b>		
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>212-30-1962</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEP 30, 1931</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Arbutus</b>		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>1101 Raven Drive</b>				10f. Zip Code <b>21227</b>		
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>				17. Father's Name (First, Middle, Last) <b>Louis Buckheit</b>		
	18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine UNK.</b>				19a. Informant's Name/Relationship (Type, Print) <b>Donald S. Riddle/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1101 Raven Drive Arbutus, MD 21227</b>		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>				20c. Location - City or Town, State <b>Baltimore, MD</b>		
	21. Signature of Funeral Service Licensee <b>Edward A. Gregorchik</b>				22. Name and Address of Facility <b>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>July 12, 2000</b>				28b. Time of Injury <b>M</b>		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Charles S. Drummond, III, M.D.</b>			
29c. License number <b>D0047930</b>				29d. Date signed (Month, Day, Year) <b>July 12, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles S. Drummond, III, M.D. 22 S. Greene Street Baltimore, MD 21201</b>			
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>				32. Registrar's Signature <b>Benjamin B. Sparks</b>				State Registrar			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23022

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SALVATORE RIGANO

2. Date of Death

Month Day Year  
July 11 2000

3. Time of Death

1545

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

102-18-6176

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 14, 1924

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

640 Meckinburg Ave #110

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

anesthesia tech asst

16b. Kind of Business/Industry

hospital

17. Father's Name (First, Middle, Last)

Joseph A. Rigano

18. Mother's Name (First, Middle, Maiden Surname)

Natale

19a. Informant's Name/Relationship (Type, Print)

Ritsuko Rigano/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

640 Meckinburg Ave #110

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Bowel

2 weeks

Due to (or as a consequence of):

b. Incarcerated Hernia

Chronic

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction x2 (pre and post Op)

Chronic Renal Failure

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN T. FORRER / THE MEMORIAL HOSPITAL

31. Date filed (Month, Day, Year)

JUL 28 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Salvatore Rigano

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND#18 PER INFMY. G786 8-15-00 State of Maryland / Department of Health and Mental Hygiene  
AMEND ITEMS: #23 PART I, 27 PER MEO G787 8-8-00-JVR

00 23023

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HOWELL WINDFIELD SMITH</b>				2. Date of Death Month Day Year <b>JULY 17, 2000</b>				3. Time of Death <b>6:51 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHOCK TRAUMA</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217 46 4369</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR 5 1944</b>		9. Birthplace (State or Foreign Country) <b>VERGINIA</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>LANDALLSTOWN</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>3995 WIS</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>14 YEAR</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTOMER ENGINEER</b>				16b. Kind of Business/Industry <b>IBM</b>	
	17. Father's Name (First, Middle, Last) <b>THOMAS SMITH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA DICKSON EMMA SMITH</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JEAN SMITH /WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3995 WHISPERING MEADOWS DRIVE LANDALLSTOWN, MD 21133</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>				20c. Location - City or Town, State <b>ARBUTUS Maryland</b>			
	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>CHATHAM HARRIS FUNERAL HOME 5340 REISTERSTOWN ROAD BALTIMORE MD 21115</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>MYOCARDIAL INFARCTION COMPLICATING A DILATED CARDIOMYOPATHY</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 19, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>										
State Registrar		31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23024

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FANNIE LEE STEVENSON

2. Date of Death

Month Day Year  
JULY 16, 2000

3. Time of Death

4:50 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

251-60-1516

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
04-05-40

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

206 N. HILTON STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12 TH GRADECollege (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DAY CARE PROVIDER

16b. Kind of Business/Industry

CHILD CARE

17. Father's Name (First, Middle, Last)

EDDIE HAMMOND

18. Mother's Name (First, Middle, Maiden Surname)

CORA ROBINSON

19a. Informant's Name/Relationship (Type, Print)

LEWIS STEVENSON, JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

206 N. HILTON ST., BALTO. MD. 21229

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK

Date

7-21-00 BALTO. MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE  
5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LYMPHOMA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joginder P. Mehta, M.D.

29c. License number

D 41410

29d. Date signed (Month, Day, Year)

July 17th, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

Joginder P. Mehta

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23025

amend item 18 per fh G785 7/20/00 yg

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSE SOLOMON</b>				2. Date of Death Month <b>July</b> Day <b>18</b> Year <b>2000</b>		3. Time of Death <b>955 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL 5601 Loch Raven Blvd</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>218-36-8245</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>08-02-35</b>		
	9. Birthplace (State or Foreign Country) <b>VA</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>535 BEAUMONT AVE</b>		10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9 TH GRADE</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>		16b. Kind of Business/Industry <b>HOME</b>		17. Father's Name (First, Middle, Last) <b>SAMUEL STONE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanora Alexander</b>	
19a. Informant's Name/Relationship (Type, Print) <b>MARY WEBB</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2602 KIRK AVENUE, BALTO. MD. 21218</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		20c. Location - City or Town, State <b>07-25-00 BALTO. MD</b>	
21. Signature of Funeral Service Licensee <b>Margh C H</b>		22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229</b>		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS - DIC</b> Due to (or as a consequence of): <b>RENAL FAILURE</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DIABETES MELLITUS</b> <b>HYPERTENSION</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier <b>Raphael Dodoo MD</b>		29c. License number <b>P12557</b>		29d. Date signed (Month, Day, Year) <b>JULY 18, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAPHAEL DODOO, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239</b>	
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature <b>Beverly Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>INEZ ESTER RUSS</b> <del>INEZ ELIZABETH RUSS</del>		2. Date of Death Month <b>JULY</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>2128 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>1775 HOMESTEAD STREET</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>218-26-2820</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>OCT. 15, 1930</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1775 HOMESTEAD STREET</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10+ GRADE</b> College (1-4or 5+) <b>DOMESTIC WORKER PRIVATE FAMILIES</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) <b>ELLIS RUSS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SADIE MORRIS</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>DELORES RUSS (SISTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3002 ARUNAH AVENUE, BALTO, MD 21216</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS CEMETERY 7-24-00</b>		20c. Location - City or Town, State <b>ARBUTUS, MARYLAND</b>
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>		
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
	23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b> 28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JULY 18, 2000</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>				
	31. Date filed (Month, Day, Year) <b>JUL 20 2000</b> 32. Registrar's Signature 				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23027

DOB - 7-16-90

SCABING, PHIBIP. DOB - 4-11-44

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Philip Elwin Sealing</b>				2. Date of Death Month <b>July</b> Day <b>16</b> Year <b>2000</b>				3. Time of Death <b>14:50 PM</b>			
4a. Facility Name (If not institution, give street and number) <b>Prince George Hospital</b>				4b. City, Town, or Location of Death <b>Cheverly</b>				4c. County of Death <b>Prince George</b>			
5. Social Security Number <b>215-44-3537</b>		6. Sex <b>XX</b> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>April 4, 1944</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>											
Usual Residence of Decedent											
10a. State <b>Md</b>		10b. County <b>Anne Arundal</b>		10c. City, Town or Location <b>Laurel</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>16 South Paula ST.</b>				10f. Zip Code <b>20724</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Laurel Race Track</b>			
17. Father's Name (First, Middle, Last) <b>Spencer Sealing</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Sylvia Leisure</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mary Sealing wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 South Paula St. Laurel, Maryland 20724</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cheasapeake Cremetory</b>		Date <b>7-22-00</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Fleck Funeral Home Inc. 7601 Sandy Spring Road LAurel, Maryland 20707</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>SEPTIC SHOCK.</b> Due to (or as a consequence of): b. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): c. <b>RENAL FAILURE</b> Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe - peripheral vascular disease.</b>											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number <b>D-34525</b>				29d. Date signed (Month, Day, Year) <b>07-17-00.</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. J. Rao, MD - 4000 Mitchellville Road; Bowie MD - 20716.</b>											
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>				32. Registrar's Signature 							

State Registrar

1767





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23028

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Moses Simon, Jr.				2. Date of Death Month Day Year July 13, 2000				3. Time of Death 9:35 AM		
	4e. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 265-15-4829		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) 07/23/1951		9. Birthplace (State or Foreign Country) NC		
	Usual Residence of Decedent										
10a. State DC		10b. County		10c. City, Town or Location Washington				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1108 McCollough Ct.				10f. Zip Code				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) 11th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Porter				16b. Kind of Business/Industry Housematic			
17. Father's Name (First, Middle, Last) Moses Simon, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Bessie Workman Snipes							
19e. Informant's Name/Relationship (Type, Print) Cora Ann Simon - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 McCollough Ct., Washington, DC							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donatory <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) QUANTICO CEMETERY				20c. Location - City or Town, State QUANTICO, VA			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Howell Funeral Home, Inc., 4600 Liberty Hgts. Baltimore, MD 21207 - (410) 664-6800							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Chronic Lymphocytic Leukemia Due to (or as a consequence of): c. Myocardial Infarction Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29c. License number D53811	
29b. Signature and title of certifier 										29d. Date signed (Month, Day, Year) July 13, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Chorrand 1500 Forest Glen Rd., Silver Spring, MD 20910											
31. Date filed (Month, Day, Year) JUL 20 2000				32. Registrar's Signature 							



Unknown 00-184

Terrill L. Scovens

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MED G/85 7-21-00 WR.

Certificate of Death

Reg. No.

00 23029

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>TERRILL L. SCOVENS</b>				2. Date of Death Month Day Year <b>July 12, 2000</b>				3. Time of Death <b>1120 am</b>							
4a. Facility Name (If not institution, give street and number) <b>723 Saint Paul Street Room #103</b>						4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>					
5. Social Security Number <b>218-84-5214</b>			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>29</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>04-07-71</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent															
10a. State <b>MD</b>			10b. County <b>N/A</b>			10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>2550 W. LOMBARD STREET</b>						10f. Zip Code <b>21223</b>				10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 TH GRADE</b> College (1-4 or 5+) <b>N/A</b>						15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>				15b. Kind of Business/Industry <b>CONSTRUCTION</b>					
17. Father's Name (First, Middle, Last) <b>LARRY NEWTON</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>DIANE SCOVENS</b>									
19a. Informant's Name/Relationship (Type, Print) <b>LEONARD SCOVENS</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 NORTH ELLAMONT ST., BALTO. MD. 21229</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>				20c. Location - City or Town, State <b>1-17-00 BALTO. MD</b>					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>CREMATION SERVICES 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>NARCOTIC INTOXICATION</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  e. Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):														Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day, Year) <b>Found: 7-12-00</b>		28b. Time of Injury <b>UNKNOWN</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN A HOTEL ROOM</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>723 ST. PAUL ST BALTIMORE, MARYLAND</b>									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>July 13, 2000</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>						32. Registrar's Signature 									

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #PART II, PER MD G785 7-25-00 WR

Certificate of Death

Reg. No.

00 23030

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GLENN DOUGLAS SMITH</b>				2. Date of Death Month Day Year <b>7/14/2000</b>		3. Time of Death <b>13:55</b>		
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTO.</b>		4c. County of Death		
Funeral Director	5. Social Security Number <b>240 44 8140</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8/13/31</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		
	10e. Street and Number <b>3600 KELOX ROAD</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. <b>AFRO</b> Specify: <b>AMERICAN</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PAINTER</b>		16b. Kind of Business/Industry <b>BETHLEHEM STEEL</b>				
	17. Father's Name (First, Middle, Last) <b>WILBERT WILLIAMS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARIE SMITH</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>RUBY D. SMITH</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3600 KELOX RD. BALTO. MD. 21207</b>				
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		Date <b>7/21/2000</b>		20c. Location - City or Town, State <b>OWINGS MILLS MD</b>		
	21. Signature of Funeral Service Licensee <i>Leulga Step</i>				22. Name and Address of Facility <b>ESTEP BROTHERS FUNERAL HOME PA.</b> <b>1300 EUTAW PL BALTO. MD 21217</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dilated cardiomyopathy</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>REACTIVE AIRWAY DISEASE</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
						24e. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Sean Atchison</i>							
		29c. License number <b>AU4176435A13044</b>		29d. Date signed (Month, Day, Year) <b>July 18, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sean Atchison, D.O. 22 South Greene Street Baltimore, MD</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 24 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23031

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Earl Andrew Swingler Sr.

2. Date of Death

Month

Day

Year

3. Time of Death

0140

4e. Facility Name (If not institution, give street and number)

Fallston General hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

214-14-1859

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2/28/1920

9. Birthplace (State or Foreign Country)

Balto City.

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Fork

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12700 Wilson Avenue

10f. Zip Code

21051

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Patapsco &amp; Bael's River RR

17. Father's Name (First, Middle, Last)

Andrew Goerge Swingler

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Silati

19e. Informant's Name/Relationship (Type, Print)

Vala J. Swingler (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21700 Wilson Avenue Fork, MD 21051

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

7/18/2000

20c. Location - City or Town, State

Balto. MD

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E.F. Lassahn Funeral Home

11750 Belair Rd. Kingsville, MD 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D16444

29d. Date signed (Month, Day, Year)

July 16 2000

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

V. J. S. Nair, MD 2112 Belair Rd. Fallston MD 21054

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Swingler, Earl A.

A-1-1





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 23032

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Sungenis

2. Date of Death  
Month Day Year

July 19 2000

3. Time of Death

10:00AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

144-10-4479

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Jan. 11 1904

10. Inside City Limits

1 ☒ Yes 2 ☐ No

Usual Residence of Decedent

10a. State

NJ

10b. County

Cumberland

10c. City, Town or Location

Vineland

10e. Street and Number

33 W Chestnut Ave Apt 22

10f. Zip Code

08360

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

printing

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Ralph Sungenis

18. Mother's Name (First, Middle, Maiden Summa)

Julia Nasuti

19a. Informant's Name/Relationship (Type, Print)

Robert Sungenis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

son 2412 John Anderson Dr. Orem, FL 32176

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart Cemetery

Date

July 22

20c. Location - City or Town, State

Vineland, NJ

21. Signature of Funeral Service Licensee

Keith S. Uebels

22. Name and Address of Facility

Evans Funeral Chapel

8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. UROSEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 DAY

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven K. Smith

29c. License number

DM35494

29d. Date signed (Month, Day, Year)

7/19/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Steven K. Smith Anne Arundel Medical Center

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-6000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

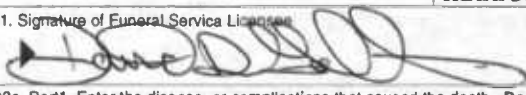
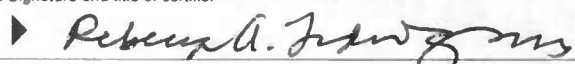



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23033

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MONICA ELIZABETH SIMPSON</b>				2. Date of Death Month <b>July</b> Day <b>16</b> , Year <b>2000</b>		3. Time of Death <b>4:15 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>180-32-3925</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 18, 1940</b>		9. Birthplace (State or Foreign Country) <b>Pa.</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Lutherville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>512 Hilltop Dr.</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Music Teacher</b>			16b. Kind of Business/Industry <b>Baltimore County Schools</b>	
17. Father's Name (First, Middle, Last) <b>Samuel E. Thomas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Osifchak</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Thomas Simpson, Sr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>512 Hilltop Dr. Lutherville, Md. 21093</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>7/18/00</b>		20c. Location - City or Town, State <b>Towson, Md.</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Hypotension</b> Due to (or as a consequence of):  b. <b>Acute renal failure</b> Due to (or as a consequence of):  c. <b>Scleroderma</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  hours  weeks  months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>cardiomyopathy secondary to scleroderma</b>  <b>congestive heart failure</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D36226</b>		29d. Date signed (Month, Day, Year) <b>7/17/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rebecca A. Ludwig, M.D. GBMC, 6701 N. Charles St. Baltimore, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23034

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ELLEN LOUISE STOVER				2. Date of Death Month Day Year July 17, 2000		3. Time of Death 11:30 AM	
4a. Facility Name (If not institution, give street and number) Baptist Home of Maryland, Rainbow Hall				4b. City, Town, or Location of Death Owings Mills		4c. County of Death Baltimore	
5. Social Security Number 176-01-1153		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 25, 1913	9. Birthplace (State or Foreign Country) Pa.
Usual Residence of Decedent							
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Reisterstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 707 Earlton Rd.				10f. Zip Code 21136		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Quiller		16b. Kind of Business/Industry Textile Manufacturing	
17. Father's Name (First, Middle, Last) Paul Plath				18. Mother's Name (First, Middle, Maiden Surname) Naomi Williams			
19a. Informant's Name/Relationship (Type, Print) Mr. Ekron Stover/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Earlton Rd. Reisterstown, Md. 21136			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Rose Cemetery		Date 7/22/00		20c. Location - City or Town, State Spring Garden Twp. Pa.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>coronary artery disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death 40 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's disease</u>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 		29c. License number D 41104		29d. Date signed (Month, Day, Year) 7.17.00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ted Houck MD, 7825 York Rd Towson MD 21204							
31. Date filed (Month, Day, Year) JUL 20 2000		32. Registrar's Signature 					





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23035

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Lester Thompson

2. Date of Death

Month Day Year  
July 11, 2000

3. Time of Death

8:10pm

4a. Facility Name (If not institution, give street and number)

32 Belfast Rd.

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-16-2281

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jun 27, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

32 Belfast Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Black and Decker

17. Father's Name (First, Middle, Last)

Thomas W. Thompson

18. Mother's Name (First, Middle, Maiden Sumama)

Ida M. Keesez

19a. Informant's Name/Relationship (Type, Print)

Michael P. Thompson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

195 Rutgers Ave., Berkeley Heights, NJ 07922

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Moreland Memorial Park

Date

Jul 15  
2000

20c. Location - City or Town, State

Parkville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel  
8800 Harford Rd. Parkville, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

acute

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:2 ☐ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D40208

29d. Date signed (Month, Day, Year)

7/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mr. June Breiner 1205 York Rd. Lutherville, Maryland

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1/10/1951

1/10/1951

1/10/1951

1/10/1951

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23036

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH DONALD TINKER

2. Date of Death

Month Year  
JULY 15 2000

3. Time of Death

6:37 AM

4a. Facility Name (If not institution, give street and number)

GILCHRIST CTR - G.B.M.C.

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

219-44-5935

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 15, 1944

9. Birthplace (State or Foreign Country)

CALIFORNIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

COCKEYSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

828 W. PADONIA

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: ARMY13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

SHEPARD PRATT

17. Father's Name (First, Middle, Last)

JOSEPH E. TINKER

18. Mother's Name (First, Middle, Maiden Surname)

TERESA A. ESKINS

19a. Informant's Name/Relationship (Type, Print)

HARRIETT TINKER, SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

828 W. PADONIA COCKEYSVILLE, MD. 21030

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SAYRE BAPTIST CHURCH. CH.

Date

JULY 17,  
2000

20c. Location - City or Town, State

LUTHERVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS FUNERAL CHAPEL

2325 YORK RD. TIMONIUM, MD. 21093

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. prim creatic cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

21 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley G.B.M.C. 16701 N. Charles St. Balto. md 21205

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

James B. Spotts

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 21 is marked other than "natural", or item 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23037

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anthony Paul Valenti</b>				2. Date of Death Month <b>July</b> Day <b>15</b> Year <b>2000</b>				3. Time of Death <b>10:45AM</b>			
	4a. Facility Name (If not Institution, give street and number) <b>Manor Care Ruxton</b>				4b. City, Town, or Location of Death <b>Ruxton</b>				4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>064-09-2175</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 6, 1914</b>		9. Birthplace (State or Foreign Country) <b>N.Y.</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Lutherville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>1316 Charmuth Rd.</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW-II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Underwriter</b>			16b. Kind of Business/Industry <b>Insurance</b>				
	17. Father's Name (First, Middle, Last) <b>Ignazio Valenti</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gaetana Benevenia</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Rose M. Valenti/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1316 Charmuth Rd. Lutherville, Md. 21093</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>7/18/00</b>		20c. Location - City or Town, State <b>Towson, Md.</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. End Stage Dementia</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 				29c. License number <b>D43725</b>				29d. Date signed (Month, Day, Year) <b>7/18/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TARIQ MAHMOOD 201-109 Back River Neck Road Baltimore MD 21221</b>												
State Registrar		31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at 0026.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



JUL 3 1961



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 28c per phys. G785 7/20/00 yg State of Maryland / Department of Health and Mental Hygiene 00 23038

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bertha White</b>				2. Date of Death Month Day Year <b>July 17, 2000</b>				3. Time of Death <b>11:00pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>906 North Caroline Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>218-12-6498</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>03-13-17</b>		9. Birthplace (State or Foreign Country) <b>NC</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>906 N. Caroline Street Apt. #302</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High Sch. Grad</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>			16b. Kind of Business/Industry <b>Gordon's Restuarant</b>		
	17. Father's Name (First, Middle, Last) <b>Jasper A. Carter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Autry</b>					
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) <b>Silas White, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>917 N. Caroline Street Baltimore, Maryland 21205</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem. 07-24-2000 Owings Mills</b>				20c. Location - City or Town, State <b>MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>COLON CANCER</b>									
	23b. Approximate Interval Between Onset and Death <b>2 months</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>COLON CANCER</b>									
	23b. Approximate Interval Between Onset and Death <b>2 months</b>									
	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>COLON CANCER</b>									
	23d. Due to (or as a consequence of): a. <b>COLON CANCER</b> b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. aa. ab. ac. ad. ae. af. ag. ah. ai. aj. ak. al. am. an. ao. ap. aq. ar. as. at. au. av. aw. ax. ay. az. ba. bb. bc. bd. be. bf. bg. bh. bi. bj. bk. bl. bm. bn. bo. bp. bq. br. bs. bt. bu. bv. bw. bx. by. bz. ca. cb. cc. cd. ce. cf. cg. ch. ci. cj. ck. cl. cm. cn. co. cp. cq. cr. cs. ct. cu. cv. cw. cx. cy. cz. da. db. dc. dd. de. df. dg. dh. di. dj. dk. dl. dm. dn. do. dp. dq. dr. ds. dt. du. dv. dw. dx. dy. dz. ea. eb. ec. ed. ee. ef. eg. eh. ei. ej. ek. el. em. en. eo. ep. eq. er. es. et. eu. ev. ew. ex. ey. ez. fa. fb. fc. fd. fe. ff. fg. fh. fi. fj. fk. fl. fm. fn. fo. fp. fq. fr. fs. ft. fu. fv. fw. fx. fy. fz. ga. gb. gc. gd. ge. gf. gg. gh. gi. gj. gk. gl. gm. gn. go. gp. gq. gr. gs. gt. gu. gv. gw. gx. gy. gz. ha. hb. hc. hd. he. hf. hg. hi. hj. hk. hl. hm. hn. ho. hp. hq. hr. hs. ht. hu. hv. hw. hx. hy. hz. ia. ib. ic. id. ie. if. ig. ih. ii. ij. ik. il. im. in. io. ip. iq. ir. is. it. iu. iv. iw. ix. iy. iz. ja. jb. jc. jd. je. jf. jg. jh. ji. jj. jk. jl. jm. jn. jo. jp. jq. jr. js. jt. ju. jv. jw. jx. jy. jz. ka. kb. kc. kd. ke. kf. kg. kh. ki. kj. kl. km. kn. ko. kp. kq. kr. ks. kt. ku. kv. kw. kx. ky. kz. la. lb. lc. ld. le. lf. lg. lh. li. lj. lk. ll. lm. ln. lo. lp. lq. lr. ls. lt. lu. lv. lw. lx. ly. lz. ma. mb. mc. md. me. mf. mg. mh. mi. mj. mk. ml. mm. mn. mo. mp. mq. mr. ms. mt. mu. mv. mw. mx. my. mz. na. nb. nc. nd. ne. nf. ng. nh. ni. nj. nk. nl. nm. nn. no. np. nq. nr. ns. nt. nu. nv. nw. nx. ny. nz. oa. ob. oc. od. oe. of. og. oh. oi. oj. ok. ol. om. on. oo. op. oq. or. os. ot. ou. ov. ow. ox. oy. oz. pa. pb. pc. pd. pe. pf. pg. ph. pi. pj. pk. pl. pm. pn. po. pp. pq. pr. ps. pt. pu. pv. pw. px. py. pz. qa. qb. qc. qd. qe. qf. qg. qh. qi. qj. qk. ql. qm. qn. qo. qp. qq. qr. qs. qt. qu. qv. qw. qx. qy. qz. ra. rb. rc. rd. re. rf. rg. rh. ri. rj. rk. rl. rm. rn. ro. rp. rq. rr. rs. rt. ru. rv. rw. rx. ry. rz. sa. sb. sc. sd. se. sf. sg. sh. si. sj. sk. sl. sm. sn. so. sp. sq. sr. ss. st. su. sv. sw. sx. sy. sz. ta. tb. tc. td. te. tf. tg. th. ti. tj. tk. tl. tm. tn. to. tp. tq. tr. ts. tu. tv. tw. tx. ty. tz. ua. ub. uc. ud. ue. uf. ug. uh. ui. uj. uk. ul. um. un. uo. up. uq. ur. us. ut. uu. uv. uw. ux. uy. uz. va. vb. vc. vd. ve. vf. vg. vh. vi. vj. vk. vl. vm. vn. vo. vp. vq. vr. vs. vt. vu. vv. vw. vx. vy. vz. wa. wb. wc. wd. we. wf. wg. wh. wi. wj. wk. wl. wm. wn. wo. wp. wq. wr. ws. wt. wu. wv. ww. wx. wy. wz. xa. xb. xc. xd. xe. xf. xg. xh. xi. xj. xk. xl. xm. xn. xo. xp. xq. xr. xs. xt. xu. xv. xw. xx. xy. xz. ya. yb. yc. yd. ye. yf. yg. yh. yi. yj. yk. yl. ym. yn. yo. yp. yq. yr. ys. yt. yu. yv. yw. yx. yy. yz. za. zb. zc. zd. ze. zf. zg. zh. zi. zj. zk. zl. zm. zn. zo. zp. zq. zr. zs. zt. zu. zv. zw. zx. zy. zz.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined										
28a. Date of injury (Month, Day Year) <b>7/18/2000</b>										
28b. Time of injury <b>M</b>										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 										
29c. License number <b>D29071</b>										
29d. Date signed (Month, Day, Year) <b>7/18/2000</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANANDAKRISHNAN 821 N. EUTAW ST # 305 BALTIMORE 21201</b>										
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>										
32. Registrar's Signature 										

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23039

AMENDED ITEM #19b PER FH G785 7/20/00 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OLIVIA</b>		2. Date of Death Month <b>JULY</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>2102</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>212-26-5699</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>4-28-1930</b>		9. Birthplace (State or Foreign Country) <b>Md</b>		
Usual Residence of Decedent					
10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1619 E. 32nd Street</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U S A</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>J. H. H. Patient Representative</b>	
17. Father's Name (First, Middle, Last) <b>Theodore Austin</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Brown</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Arlene Johnson Taylor</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1619 WINFORD ROAD BALTIMORE, MD 21239</b> <b>1718 Lakeside Avenue Baltimore, Md 21239</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. Location - City or Town, State <b>7-21-00 Arbutus, Md</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Avenue Baltimore, Md 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pulmonary Embolus</b> Due to (or as a consequence of): <b>Bedbound State and Immobilization</b> Due to (or as a consequence of): <b>Mechanical ventilation</b> Due to (or as a consequence of): <b>Upper Airway obstruction</b>				Approximate Interval Between Onset and Death <b>45 minutes</b> <b>3 weeks</b> <b>2 weeks</b> <b>2 weeks</b>	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Hypertension</b> <b>Coronary Artery Disease</b>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>RES-000</b>	
29d. Date signed (Month, Day, Year) <b>JULY 17, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Craig S. Smith MD 600 N. Wolfe Street Tower 110 Johns Hopkins Hospital Baltimore MD 21287</b>					
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23040

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET ELIZABETH WILLIAMS

2. Date of Death

Month Day Year  
July 15 2000

3. Time of Death

11:16 AM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

21952 6999

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 8, 1949

9. Birthplace (State or Foreign Country)

S. Carolina

Usual Residence of Decedent

10a. State  
Maryland10b. County  
BALTIMORE

10c. City, Town or Location

Randallstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3834 BROWN HILL ROAD

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNT RECEIVABLE MANAGER CAREER COMMUNICATION GROUP

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

FALAS MOBLEY, SR.

18. Mother's Name (First, Middle, Maiden Surname)

WILLIE SEIBLER

19a. Informant's Name/Relationship (Type, Print)

Walter Williams / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3834 BROWN HILL ROAD RANDALLSTOWN, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brimson Forest Veterans Cemetery

Date

7-19-2000 Wings Mills, Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Debra Harris

22. Name and Address of Facility

CHARTERED - HARRIS F.H.  
5240 REISTERSTOWN ROAD  
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Cardio Renal  
Due to (or as a consequence of):  
b. Vascular Disease  
Due to (or as a consequence of):  
c.  
Due to (or as a consequence of):  
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

Charles F. O'Donnell MD

29c. License number

D-09383

29d. Date signed (Month, Day, Year)

July 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell MD

111 Hamlet Hill Rd  
Baltimore MD 21210

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

Benny B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23041

Amend Item 1 per DR,G789,11/08/00dhb

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ADA H. WEAVER <u>Ada V Weaver</u>				2. Date of Death Month 7 Day 14 Year 2,000		3. Time of Death 8:00 AM		
	4a. Facility Name (If not institution, give street and number) <u>3700 Eastman Rd</u>				4b. City, Town, or Location of Death <u>PIKESVILLE</u>		4c. County of Death <u>BALTIMORE</u>		
Funeral Director	5. Social Security Number <u>214-40-5861</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>81</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>10-02-18</u>		
	9. Birthplace (State or Foreign Country) <u>MD</u>		10a. State <u>MD</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>PIKESVILLE</u>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>8014 SUNSTONE CIRCLE</u>		10f. Zip Code <u>21208</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12TH GRADE</u> College (1-4 or 5+) <u>1 YRS</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>PRINCIPAL</u>		16b. Kind of Business/Industry <u>BALTO. CITY</u>		17. Father's Name (First, Middle, Last) <u>ROBERT HACKETT</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>MARY GROOMS</u>	
19a. Informant's Name/Relationship (Type, Print) <u>WARREN WEAVER / SON</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8014 SUNSTONE CIR., PIKESVILLE, MD. 21208</u>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>METRO CREMATORY</u>		20c. Location - City or Town, State <u>1-18-00 BALTO. MD</u>	
21. Signature of Funeral Service Licensee <u>Daugh C H</u>		22. Name and Address of Facility <u>CREMATION SERVICES</u> <u>5151 BALTO. NATL PIKE, BALTO. MD. 21229</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>CEREBROVASCULAR ACCIDENT</u> Due to (or as a consequence of): b. <u>ARTEROSCLEROSIS</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>ASSISTED LIVING</u>		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>WANDEN J. SMITH MD</u>		29c. License number <u>024148</u>		29d. Date signed (Month, Day, Year) <u>7-17-2000</u>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>WARREN SMITH MD 3502 W. ROBERTS AVE #6 BALTO MD 21215</u>	
31. Date filed (Month, Day, Year) <u>JUL 20 2000</u>		32. Registrar's Signature <u>B. Sparks</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

500 2 17

1000 2 17

1000 2 17

1000

1000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23042

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARTHUR NICHOLAS WILLIAMS, JR.				2. Date of Death Month Day Year JULY 18, 2000				3. Time of Death 4:48 AM		
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 219 40 3123		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) 11/22/42		9. Birthplace (State or Foreign Country) Md		
	Usual Residence of Decedent										
10a. State Md.		10b. County W. A.		10c. City, Town or Location Balt'o				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 2100 Clowville Ave				10f. Zip Code 21214				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 3/10/66		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance				16b. Kind of Business/Industry Cardiff HALL-Apts			
17. Father's Name (First, Middle, Last) Arthur L Williams				18. Mother's Name (First, Middle, Maiden Surname) Mary Coleman							
19a. Informant's Name/Relationship (Type, Print) PATRICIA WILLIAMS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 Clowville Ave Balt'o. Md 21214							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Barnum Forest Cem		Date 7/25/00		20c. Location - City or Town, State Orange Mills Md					
21. Signature of Funeral Service Licensee Joseph B. Rocks Jr				22. Name and Address of Facility Joseph B. Rocks Jr / H 1304 N. Central Ave							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) PNEUMONIA  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Timothy Low, M.D.				29c. License number D 24034				29d. Date signed (Month, Day, Year) 7/18/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204											
31. Date filed (Month, Day, Year) JUL 20 2000		32. Registrar's Signature Benjamin B. Sparks									

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23043

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Williams

2. Date of Death

July 17, 2000

3. Time of Death

1:35 pm

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

427-84-7339

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

March 11, 1900

9. Birthplace (State or Foreign Country)

MS

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3296 Sudlersville South

10f. Zip Code

20724

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Share Cropper

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Mamon Claiborne

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Unknown

19a. Informant's Name/Relationship (Type, Print)

Hattie Lloyd / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3296 Sudlersville South, Laurel Maryland 20724

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Forest Grove Cemetery July 26, 2000

Date

20c. Location - City or Town, State

Patterson, MS

21. Signature of Funeral Service Licensee

Victor P. Doda, Jr.

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue, Baltimore MD 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Sepsis

e. Due to (or as a consequence of):

Pneumonia

b. Due to (or as a consequence of):

Chronic Renal Failure

c. Due to (or as a consequence of):

Pleural Effusion

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► [Signature] MD Attending

29c. License number

D 42580

29d. Date signed (Month, Day, Year)

7-17-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5632 Annapolis Rd #13 BLADENSBURG MD - 20710

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
0004.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23044

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM MEHL</b>				2. Date of Death Mnth Day Year <b>JULY 17 2000</b>		3. Time of Death <b>21=55</b>	
	4e. Facility Name (If not institution, give street and number) <b>SR FALLSTON GENERAL HOSP</b>				4b. City, Town, or Location of Death <b>FALLSTON</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>212-48-0738</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sep 15, 1947</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>833 Flintlock Dr.</b>				10f. Zip Code <b>21015</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer analyst</b>			16b. Kind of Business/Industry <b>MedStar</b>	
17. Father's Name (First, Middle, Last) <b>William A. Mehl</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Doris Hahn</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Dawn Mehl</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>833 Flintlock Dr., Bel Air, MD 21015</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evans Funeral Chapel-Bel Air</b>			20c. Location - City or Town, State <b>Forest Hill, MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Evans Funeral Chapel 8800 Harford Rd. Parkville, MD</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CANCER</b> Due to (or as a consequence of): <b>b. CANCER OESOPHAGUS</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 					29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JULY 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GS PLABHU M.S 728 BELAIR MD BELAIR MD 21014</b>								
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>			32. Registrar's Signature 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#5 per FHG787 9/15/2000  
amend item 19a per informant G786 8/25/00 yg

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23045

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Benjamin Whitney

2. Date of Death  
Month Day Year

7 9 2000 240 pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Alice Byrd Tawes Nursing Home

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

5. Social Security Number

214-12-5664

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 17, 1910

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

201 Hall Highway

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

rigger

16b. Kind of Business/Industry

steel

17. Father's Name (First, Middle, Last)

John A. Whitney

18. Mother's Name (First, Middle, Maiden Surname)

Hattie E. Evans

19a. Informant's Name Relationship (Type, Print)

Hattie White / daughter  
Hattie Wilson / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 307 Fallston, NC 28042

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

Metastatic Osteogenic Sarcoma

b.

Due to (or as a consequence of):

Paget's Disease

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 48098

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

VITAY K KARUMBONATHAN, TAWES NURSING CENTER

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

Beverly B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

amend item 1,25 per phys. G785 7/20/00 yg State of Maryland / Department of Health and Mental Hygiene 00 23046  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <del>ALICE E. YOUNKER</del> ALICE E. YOUNKER				2. Date of Death Month Day Year June 19, 2000		3. Time of Death 5:25 PM		
	4a. Facility Name (If not institution, give street and number) MONTCLAIR MANOR				4b. City, Town, or Location of Death Fulton		4c. County of Death Howard		
Funeral Director	5. Social Security Number 221-32-4632		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Oct 24, 1907		
	9. Birthplace (State or Foreign Country) IL		10a. State MD		10b. County Howard		10c. City, Town or Location Fulton		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 11805 Wayneridge Street		10f. Zip Code 20759		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife		16b. Kind of Business/Industry none					
17. Father's Name (First, Middle, Last) David W. Holt				18. Mother's Name (First, Middle, Maiden Surname) Ora A. Hawley					
19a. Informant's Name/Relationship (Type, Print) Celeste Ferrell/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Trickle Stone Ct Holland, MI 49424					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		e. <u>Adenocarcinoma of the lung</u> Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive Heart Failure</u> <u>Dementia</u>		23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>M. Summers</u>		29c. License number D40413		29d. Date signed (Month, Day, Year) July 1, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Marquerite Summers, MD 2 Knoll N. Drive Columbia, MD 21045		31. Date filed (Month, Day, Year) Jul 20 2000		32. Registrar's Signature <u>Benjamin S. Sparks</u>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 23047

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roy L. Arnold Sr.

2. Date of Death  
Month Day Year

July 18, 2000

3. Time of Death

8:00 PM DST

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2339 Neudecker Road

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

217-12-9552

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-21-1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2339 Neudecker Road

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 44-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

MTA

17. Father's Name (First, Middle, Last)

Hunter F. Arnold

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Franklin

19a. Informant's Name/Relationship (Type, Print)

Roy L. Arnold Jr. son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 West South Street Kennett Square PA 19348

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Mem. Cemetery

Date

7-21-00

20c. Location - City or Town, State

Finksburg, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

11824 Reisterstown Road

Eline Funeral Home Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Immediate

Due to (or as a consequence of):

b. Atherosclerotic Coronary Heart Disease

13 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Congestive Heart Failure

Prior Myocardial Infarctions

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Henry J. Babitt, M.D.

29c. License number

D00337

29d. Date signed (Month, Day, Year)

July 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Henry J. Babitt, M.D. 1838 Greene Tree Rd Ste 35 Balt, Md 21208

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Beverly Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23048

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan P. Boling				2. Date of Death Month Day Year July 20 2000				3. Time of Death 833 pm						
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 212 32 6513		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Sept. 17, 1934		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent														
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Middle River						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 204 Wampler Rd.						10f. Zip Code 21220				10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Rhodes A. Campbell						18. Mother's Name (First, Middle, Maiden Surname) Amelia E. Kreiner									
19a. Informant's Name/Relationship (Type, Print) John Boling Sr. (Husband)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Wampler Rd. Baltimore, Md. 21220									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Mem. Gardens 7/24/2000				Date 7/24/2000		20c. Location - City or Town, State Bel Air, Md.					
21. Signature of Funeral Service Licensee John W. Buckowski						22. Name and Address of Facility Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pancreatic Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier Virginia Yo						29c. License number RD 203257				29d. Date signed (Month, Day, Year) 7/20/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Virginia Yo 9000 Franklin Square Drive Baltimore Maryland 21237															
31. Date filed (Month, Day, Year) JUL 21 2000				32. Registrar's Signature B. Sparks											

ORIGINAL

1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23049

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Herman Butler</b>		2. Date of Death Month <b>July</b> Day <b>20</b> Year <b>2000</b>		3. Time of Death <b>00:50</b>									
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>									
Funeral Director	5. Social Security Number <b>219-18-9365</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.									
	8. Date of Birth (Month, Day, Year) <b>06-25-25</b>		9. Birthplace (State or Foreign Country) <b>MD</b>											
Usual Residence of Decedent														
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>										
10e. Street and Number <b>2637 Beryl Avenue</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>										
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>												
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>		16b. Kind of Business/Industry <b>Continental Can Co.</b>												
17. Father's Name (First, Middle, Last) <b>Herbert Hart</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Butler</b>											
19e. Informant's Name/Relationship (Type, Print) <b>Dorothy M. Hamilton</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21239 1902 Heathfield Road Baltimore, Maryland</b>											
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Cem.</b>		20c. Location - City or Town, State <b>07-24-2000 Towson, MD</b>										
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Sepsis</b></td> <td>Approximate Interval Between Onset and Death <b>17 days</b></td> </tr> <tr> <td>b. <b>Multiple CVA's</b></td> <td><b>2 days</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Sepsis</b>	Approximate Interval Between Onset and Death <b>17 days</b>	b. <b>Multiple CVA's</b>	<b>2 days</b>	c.		d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Sepsis</b>	Approximate Interval Between Onset and Death <b>17 days</b>												
	b. <b>Multiple CVA's</b>	<b>2 days</b>												
	c.													
	d.													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
<table border="1"> <tr> <td><b>Cholestasis</b></td> <td>23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td><b>CAD</b></td> <td>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td></td> <td>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>						<b>Cholestasis</b>	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	<b>CAD</b>	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
<b>Cholestasis</b>	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
<b>CAD</b>	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 		29c. License number <b>Q8865</b>		29d. Date signed (Month, Day, Year) <b>July 20, 2000</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tina Newman, MD Johns Hopkins 600 N. Wolfe St, Baltimore MD 21287</b>														
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature 												

2405.3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23050

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John H. Baumgart, Jr

2. Date of Death

July 16 2000

3. Time of Death

1746

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital Glen Burnie

4b. City, Town, or Location of Death

4c. County of Death

AA

5. Social Security Number

216 16 0710

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 21, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8430 Church Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

National Institute

For Health

17. Father's Name (First, Middle, Last)

John Henry Baumgart Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Anna Marie Horney

19a. Informant's Name/Relationship (Type, Print)

Nancy Wilson / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

129 Reed Lane Simpsonville, Kentucky 40067

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

7/20/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Donna Branciarowski

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

7/16/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

William P. Jones, MD

695 America 21035

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

James P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

0600

There is a small amount of rain  
in the morning, but it is not much.  
The weather is very pleasant.

The temperature is about 60 degrees  
in the morning, and it is very  
pleasant.

The wind is very light, and it is  
very pleasant.

The sun is very bright, and it is  
very pleasant.

The clouds are very light, and it is  
very pleasant.

The moon is very bright, and it is  
very pleasant.

The stars are very bright, and it is  
very pleasant.

The planets are very bright, and it is  
very pleasant.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23051

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MELTON</b>		2. Date of Death Month <b>JULY</b> Day <b>18</b> Year <b>2000</b>		3. Time of Death <b>1:05pm</b>
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>247-36-2366</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>10-31-26</b>	9. Birthplace (State or Foreign Country) <b>SC</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1025 N. Kenwood Avenue</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High Sch. Grad</b> College (14 or 5+) <b>NA</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Supervisor</b>		16b. Kind of Business/Industry <b>Baltimore Gas &amp; Electric Co.</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>John Carter</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie McCulloh</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Adell Carter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1025 N. Kenwood Avenue Baltimore, MD. 21205</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem. 07-24-2000 Owings Mills</b>		20c. Location - City or Town, State <b>MD.</b>
	21. Signature of Funeral Service Licensee <b>Lady W...</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Prostate Cancer</b>				
23b. Approximate Interval Between Onset and Death <b>5 years</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hyperkalemia, Dehydration, Anemia, Renal Failure</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <b>M</b>					
28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No <input type="checkbox"/>					
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Peter Johnston, MD</b>					
29c. License number <b>RES-000</b>					
29d. Date signed (Month, Day, Year) <b>July 18, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter Johnston, MD 600 N. WOLFE ST. BALTIMORE, MD 21287</b>					
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>					
32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12005

12005

12005

12005

12005

12005

12005

12005

12005



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23052

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dawn Ann Cragg

2. Date of Death

Month Day Year  
July 18, 2000

3. Time of Death

11:30 P.M.

4a. Facility Name (If not Institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215-74-5398

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 19, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2047 Annapolis Road

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5th

College (1-4or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

James E. Cragg

18. Mother's Name (First, Middle, Maiden Surname)

Harriet J. Thompson

19a. Informant's Name/Relationship (Type, Print)

Harriet J. Cragg (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2047 Annapolis Road Baltimore, Maryland 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery

Date

7/21/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.  
237 E. Patapsco Avenue Baltimore, Maryland 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Bradyarrhythmia

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

d. Urinary Tract Infection

Approximate  
Interval Between  
Onset and Death

minutes

minutes

years

days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sacral Decubitus Ulcer

Congestive Heart Failure

Mental Retardation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P-17599

29d. Date signed (Month, Day, Year)

July 19 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Caton Ave Baltimore, MD 21227

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

State  
Registrar

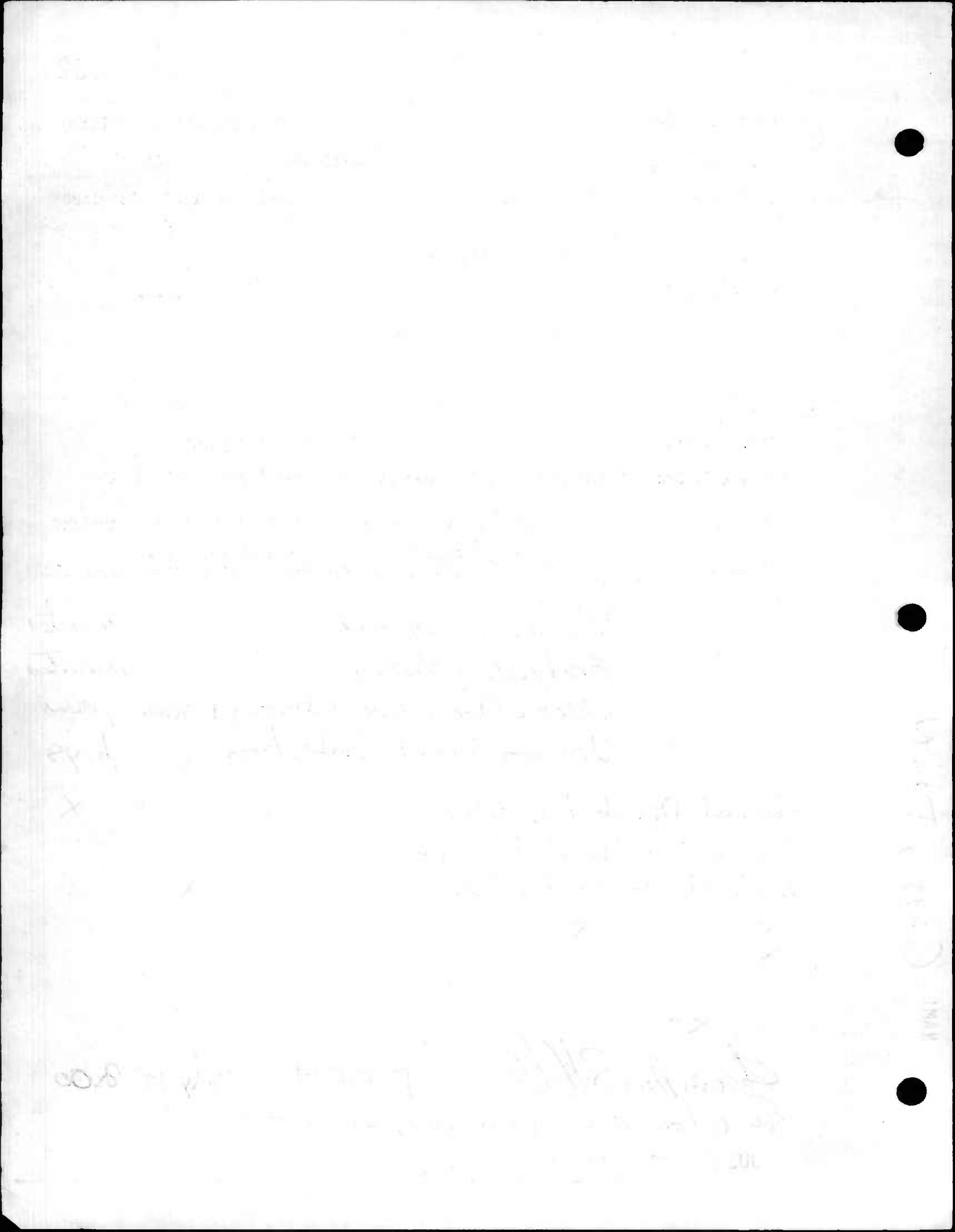
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
0020.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: Dawn Cragg  
Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23053

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Inez Louise Crisafulli				2. Date of Death Month Day Year July 16 2000		3. Time of Death 8:30 am		
	4a. Facility Name (If not institution, give street and number) Annapolis Nursing and Rehabilitation				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 023-26-4373		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 16, 1912		
	9. Birthplace (State or Foreign Country) New Hampshire		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 900 Van Buren Street		10f. Zip Code 21401		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) James V. Baldassaro				18. Mother's Name (First, Middle, Maiden Surname) Emelia D. Prizio					
19a. Informant's Name/Relationship (Type, Print) Richard J. Crisafulli (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Clifton Lane, Algood, TN 38506					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Baltimore, MD		20d. Date 7/18/00			
21. Signature of Funeral Service Licensee Michael P. Kutta				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of): Bacterial pneumonia		Approximate Interval Between Onset and Death 2 wk					
Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):					
Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):					
Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number 032036		29d. Date signed (Month, Day, Year) 7/17/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. J. [Signature] 21012 Park Drive Chester, MD 21619		31. Date filed (Month, Day, Year) JUL 21 2000		32. Registrar's Signature [Signature]					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

FRANK  
CAMPBELL

State of Maryland / Department of Health and Mental Hygiene  
AMEND ITEMS: #23 PART I, 27. 28A-F PER MEO G785 7-27-00 WR.

Certificate of Death

Reg. No.

00 23054

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Wilson Campbell						2. Date of Death Month Day Year JULY 18, 2000		3. Time of Death 5:30P.M.						
	4a. Facility Name (If not institution, give street and number) 216 WINELANE LANE				4b. City, Town, or Location of Death STEVENSVILLE		4c. County of Death QUEEN ANNES								
Funeral Director	5. Social Security Number 229-32-2375		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 21, 1931		9. Birthplace (State or Foreign Country) Virginia						
	Usual Residence of Decedent														
10a. State MD		10b. County Queen Annes		10c. City, Town or Location Stevensville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 517 Chesapeake Avenue				10f. Zip Code 21666		10g. Citizen of What Country? USA									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crane Operator				16b. Kind of Business/Industry Railroad							
17. Father's Name (First, Middle, Last) Floyd Campbell						18. Mother's Name (First, Middle, Maiden Surname) Crystal Mabery									
19a. Informant's Name/Relationship (Type, Print) Dawn Ditty (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Queens Colony Highroad, Stevensville, MD 21666											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		Date 07/24 2000		20c. Location - City or Town, State Crownsville, MD								
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401										
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) DROWNING AND COMPRESSIONAL ASPHYXIA  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE												
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) Found: 7-18-00		28b. Time of Injury UNKNOWN		28c. Injury et Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred SUBJECT UNDER TRACTOR IN CREEK						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) CREEK			28f. Location (Street and Number or Rural Route Number, City or Town, State) 216 WINELANE LANE STEVENSVILLE, MD												
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 19, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPPLE M.D., 111 Penn Street, Baltimore, Maryland 21201															
State Registrar		31. Date filed (Month, Day, Year) JUL 20 2000		32. Registrar's Signature 											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23055

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen B. Cassidy

2. Date of Death

Month Day Year  
July 18, 2000

3. Time of Death

1:10 A.M.

4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric &amp; Rehab Center

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

210-16-8928

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9-28-06

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6708 Fordcrest Road

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Election Board

17. Father's Name (First, Middle, Last)

Harry D'Adamo

18. Mother's Name (First, Middle, Maiden Surname)

Mary Cieri

19a. Informant's Name/Relationship (Type, Print)

Lolita Fales/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6708 Fordcrest Road, Baltimore, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holy Redeemer Cem

Date

7-22-00 Baltimore, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cvach/Rosedale Funeral Home  
1211 Chesaco Avenue, Baltimore, MD 2123723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Coronary heart disease

Approximate  
Interval Between  
Onset and Death

2 Days

Due to (or as a consequence of):

b.

Dementia + BP DM

5 + yrs.

Due to (or as a consequence of):

c.

COPD

10 yrs +

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 14221

29d. Date signed (Month, Day, Year)

7-19-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. A. Brown 223 E. Main Baltimore MD 21224

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

J. A. Brown

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

PERMEO G786 8-18-00 WR.

Reg. No.

00 23056

Certificate of Death

1. Decedent's Name (First, Middle, Last) <b>William Benjamin Davison II</b>		2. Date of Death Month Day Year <b>JULY 09, 2000</b>		3. Time of Death <b>11:50 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>20533 STRATH HAVEN DRIVE</b>			4b. City, Town, or Location of Death <b>Montgomery Village</b>		4c. County of Death <b>MONTGOMERY</b>
5. Social Security Number <b>202-12-9845</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b>	8. Date of Birth (Month, Day, Year) <b>June 17, 1940</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Montgomery Village</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>20533 Strath Haven Drive</b>			
10f. Zip Code <b>20886</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Procurement Analyst</b>		16b. Kind of Business/Industry <b>U.S. Government</b>			
17. Father's Name (First, Middle, Last) <b>William B. Davison</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Towner</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Kenneth L. Brown - Personal Rep.</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>33637</b> <b>8875 Hidden River Parkway, Suite 300, Tampa, Florida</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Lebanon Cemetery</b>		20c. Location - City or Town, State <b>7/17/00 Pittsburgh, Penna.</b>	
21. Signature of Funeral Service Licensee <b>Robert L. Williams</b>		22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home</b> <b>26401 Ridge Road, Damascus, Maryland 20872-0117</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARDIAC ARRHYTHMIA</b>					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>					
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURE DISORDER</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Dennis J. Chuteau</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JULY 10, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chuteau 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 303-555-1234.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23057

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine Dumlér

2. Date of Death

July 19 2000 8:20 pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

212-01-7028

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 25, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

10212 Calvery Rd.

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

William O'Brennan

18. Mother's Name (First, Middle, Maiden Summa)

Ruth Bushman

19a. Informant's Name/Relationship (Type, Print)

Theresa deRoberts

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10212 Cabery Road Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

All County Cremation Services, Inc.

Date

07/21/00

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

S. H. H. M01113

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Chronic Obstructive Pulmonary Disease

Approximate  
Interval Between  
Onset and Death

years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carmen Salvaterra

29c. License number

D33627

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARMEN SALVATERRA

10724 Little Patuxent Pkwy Columbia, MD

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

S. H. H.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
office.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23058

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Teresa Ann Day

2. Date of Death

Month Day Year  
July 19, 2000

3. Time of Death

6:40 PM

4a. Facility Name (If not institution, give street and number)

Oak Lodge Assisted Living

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

218-14-9427

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 22, 1913

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7785 New York Lane Glen Burnie

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

John Hairsine

18. Mother's Name (First, Middle, Maiden Surname)

Florence Burke

19a. Informant's Name/Relationship (Type, Print)

Florence P. Gravel - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

244 Old Magothy Bridge Road, Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

July 24

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stallings Funeral Home, P.A.

3111 Mountain Road, Pasadena, MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Approximate  
Interval Between  
Onset and Death

3 yrs

Due to (or as a consequence of):

b. Hypertension

5 yrs

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DS0108

29d. Date signed (Month, Day, Year)

7/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Downing MD 7845 Oakwood Rd., Suite #201, Glen Burnie, MD. 21061

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-327-1000.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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B.K.S

AMEND ITEMS: #23 PART I, State of Maryland / Department of Health and Mental Hygiene  
DIANE LORRAINE ELGES 27, 28A-F PER MEO G785 7-

## Certificate of Death

Reg. No.

00 23059

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Diane Lorraine Elges				2. Date of Death Month Day Year JULY 16, 2000				3. Time of Death 0930 AM					
	4a. Facility Name (If not institution, give street and number) 3435 CHAPMAN ROAD				4b. City, Town, or Location of Death RANDALLSTOWN				4c. County of Death BALTIMORE					
Funeral Director	5. Social Security Number 461-13-3938		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) March 11, 1956		9. Birthplace (State or Foreign Country) Germany	
	Usual Residence of Decedent													
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Randallstown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
10e. Street and Number 3435 Chapman Road				10f. Zip Code 21133				10g. Citizen of What Country? U.S.A.						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CPR Instructor				16b. Kind of Business/Industry Red Cross						
17. Father's Name (First, Middle, Last) William Elges								18. Mother's Name (First, Middle, Maiden Surname) Joan Bott						
19a. Informant's Name/Relationship (Type, Print) Paul Clement (Husband)								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3435 Chapman Road, Randallstown, Maryland 21133						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Wash. Crematory				Date 7/20/00		20c. Location - City or Town, State Laurel, Maryland				
21. Signature of Funeral Service Licensee 								22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, Maryland 21133						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  NARCOTIC INTOXICATION  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) AT SCENE										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) FOUND: 7-16-00		28b. Time of Injury FOUND: 9:20		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE														
28f. Location (Street and Number or Rural Route Number, City or Town, State) 3435 CHAPMAN RD. RANDALLSTOWN, MD.														
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 								29c. License number O.C.M.E				29d. Date signed (Month, Day, Year) JULY 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201														
31. Date filed (Month, Day, Year) JUL 21 2000				32. Registrar's Signature 										

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 23060

AMENDED ITEM #1 PER FH G785 7/21/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>James Ferrell</u>				2. Date of Death Month <u>07</u> Day <u>14</u> Year <u>00</u>				3. Time of Death <u>2:30 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>213-34-4208</u>		6. Sex <u>M</u> <input type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) <u>63</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>3-9-1937</u>		9. Birthplace (State or Foreign Country) <u>Md</u>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <u>Md</u>		10b. County <u>NA</u>		10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <u>1102 Druid Hill Avenue</u>				10f. Zip Code <u>21201</u>		10g. Citizen of What Country? <u>U.S.A</u>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th grade</u> College (1-4 or 5+) <u>2 years</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Disabled</u>			16b. Kind of Business/Industry <u>NA</u>		
	17. Father's Name (First, Middle, Last) <u>Hugh Ferrell</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Sarah Daniels</u>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Tonya U. Taylor -</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>12347 Bonfire Drive Reisterstown, Md 21136</u>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Garrison Forest</u>		20c. Location - City or Town, State <u>17-20-00 Owings Mills, Md</u>					
	21. Signature of Funeral Service Licensee <u>John B. Johnson</u>				22. Name and Address of Facility <u>March F.H. West 4300 Wabash Avenue Baltimore, Md 21215</u>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Ventricular Tachycardia</u> Due to (or as a consequence of):  b. <u>Lung Cancer</u> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <u>10 min</u>  <u>1 month</u>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature] MD</u>		29c. License number <u>P381234</u>		29d. Date signed (Month, Day, Year) <u>7.14.00</u>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>Garrettson Ellis 22 South Greene Street Baltimore, MD 21201</u>										
31. Date filed (Month, Day, Year) <u>JUL 21 2000</u>		32. Registrar's Signature <u>[Signature]</u>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23061

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dominic Thomas Ferracchi

2. Date of Death

Month Day Year  
July 20, 2000

3. Time of Death

3:15 pm

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216 16 1459

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)  
Aug. 5, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1209 Gettig Rd.

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Insurance Adjuster

16b. Kind of Business/Industry

Insurance Co.

17. Father's Name (First, Middle, Last)

Vincent Ferracchi

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Romeo

19a. Informant's Name/Relationship (Type, Print)

Joan Parsons (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

838 Middlesex Rd. Baltimore, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens Of Faith Cemetery 7/24/2000 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John W. Burkawski

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.  
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Tariq Mahmood

State  
RegistrarJuly 20, 2000 3:15 p.m.  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDominic Ferracchi  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23062

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Fisher

2. Date of Death

Month Day Year  
July 19, 2000

3. Time of Death

6:15P.M

4a. Facility Name (If not institution, give street and number)

3511 Chestnut Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-26-5824

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 14, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3511 Chestnut Ave

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

George Bayne

18. Mother's Name (First, Middle, Maiden Sumama)

Estella Bagley

19a. Informant's Name/Relationship (Type, Print)

Debra B. Pastore (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

712 Berry Street Baltimore, MD 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore National

Date

7/24

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.  
3631 Falls Rd. Balto, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adult macasms  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic cardiomyopathy  
Due to (or as a consequence of):

4 years

c. Multivessel coronary artery disease  
Due to (or as a consequence of):

4 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal bleeding

Cerebrovascular accident

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31025

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carla Wolf Rosenthal MD, 3333 N. Calvert Street #325, Baltimore MD 21218

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23063

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arthur Glover, Jr.</b>				2. Date of Death Month Day Year <b>July 19, 2000</b>				3. Time of Death <b>10:12am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Joseph Ritchie Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>216-34-4963</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07-19-39</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>819 N. Glover Street</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>		16b. Kind of Business/Industry <b>St. Joseph Hospital</b>						
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Arthur Glover, Jr.</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Estelle Jenkins</b>						
	19e. Informant's Name/Relationship (Type, Print) <b>Gloria Carter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>819 N. Glover Street Baltimore, Maryland 21205</b>						
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem.</b>		Date <b>07-22-2000</b>		20c. Location - City or Town, State <b>Randallstown, MD.</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Squamous cell carcinoma (R) oropharynx</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>7 months</b>		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
State Registrar	29b. Signature and title of certifier 				29c. License number <b>D02175</b>		29d. Date signed (Month, Day, Year) <b>7-19-00</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Roife B. Finn 8824 Winands Road, Randallstown, MD 21133</b>										
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature 									

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23064

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IDA VIRGINIA GARRETTSON

2. Date of Death

July 15 2000

3. Time of Death

9:15 A.M.

4a. Facility Name (If not institution, give street and number)

1741 Peppermint Lane

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

220-09-3202

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 16, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

3530 Resource Drive, Apt 220

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

John Baxter

18. Mother's Name (First, Middle, Maiden Surname)

Sadie A. Robinson

19a. Informant's Name/Relationship (Type, Print)

Lois V. Harris-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1741 Peppermint Lane, Westminster, Maryland 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

7/18/00

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Loring Byers Funeral Directors, Inc.

8728 Liberty Road, Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. non-small-cell lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

DAUGHTER'S HOME

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Dr. O. W. M. M.D.

D34406

July 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard P. Allan, 1645 Liberty Rd., Eldersburg, MD 21784

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Benjamin P. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23065

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louetta Anna Hughes

2. Date of Death

Month  
JulyDay  
16Year  
2000

3. Time of Death

0400

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Chesapeake Woods Nursing Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

219 01 4052

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
March 28, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Woolford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1536 Deep Point Rd.

10f. Zip Code

21677

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ernest J. Matusky

18. Mother's Name (First, Middle, Maiden Surname)

Mary Wolf

19a. Informant's Name/Relationship (Type, Print)

Edward E. Hughes (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1536 Deep Point Rd. Woolford, Md. 21677

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens 7/19/2000

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

John W. Burkowski

22. Name and Address of Facility

Bruzdziński Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

b. Chronic Debilitated State

Due to (or as a consequence of):

5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia, Alzheimer Type

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Fadden MD

29c. License number

D26388

29d. Date signed (Month, Day, Year)

JULY 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Fadden MD 302 Collins Ave Hurlock Md 21643

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Beverly A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23066

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Helen Heinlien</b>		2. Date of Death Month <b>JULY</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>2117 PM</b>			
4a. Facility Name (If not institution, give street and number) <b>219 OAKWOOD ROAD</b>			4b. City, Town, or Location of Death <b>DUNDALK</b>		4c. County of Death <b>BALTIMORE</b>		
5. Social Security Number <b>213-18-3157</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 8, 1922</b>	
9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>219 Oakwood Rd.</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 Yrs</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>John Pryzby</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Rolnick</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Millard Heinlien son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>75 Broadship Rd. Dundalk, Md. 21222</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		20c. Date <b>July 24, 2000</b>		20d. Location - City or Town, State <b>Rosedale, Md.</b>	
21. Signature of Funeral Service Licensee <b>Anthony C. Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222</b>					
23a. Part I: Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b>  Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Therese M. King</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JULY 20, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Therese M. King</b>		31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>				32. Registrar's Signature <b>Sparks</b>	





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23067

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Haru HAMADA

2. Date of Death

July 17, 2000

3. Time of Death

3:13 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

212-86-2497

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 15, 1900

9. Birthplace (State or Foreign Country)

Japan

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7986 Nolcrest Road

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

UNK

Kanazaki

18. Mother's Name (First, Middle, Maiden Surname)

Toku

UNK

19a. Informant's Name/Relationship (Type, Print)

Mitsuko Noone (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7986 Nolcrest Road, Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Epiphany Episcopal Cem.

Date

07/20  
2000

20c. Location - City or Town, State

Odenton, MD

21. Signature of Funeral Service Licensee

Michael G. Kutto

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute respiratory distress syndrome

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. aspiration pneumonia

Due to (or as a consequence of):

1 week

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stuart Jacobs MD

29c. License number

022483

29d. Date signed (Month, Day, Year)

July 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUART JACOBS MD 200 Hospital Dr. Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

ORIGINAL

Homada, Haru

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23068

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth A. Jarrells				2. Date of Death Month Day Year July 17, 2000		3. Time of Death 6:10 PM		
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 217-38-5881		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 1, 1922		
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Gambrills		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2335 Mt. Tabor Road		10f. Zip Code 21054		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Walter Atkins				18. Mother's Name (First, Middle, Maiden Surname) Unknown					
19a. Informant's Name/Relationship (Type, Print) Clyde R. Jarrells (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2335 Mt. Tabor Road, Gambrills, MD 21054					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		Date 07/17 2000		20c. Location - City or Town, State Glen Burnie, MD			
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Aspiration Pneumonia Due to (or as a consequence of): Amyotrophic Lateral Sclerosis  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  { c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature] MD		29c. License number D48006		29d. Date signed (Month, Day, Year) July 19th, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KORI BOMTEY, 301 Hospital Dr, Glen Burnie, MD 21061		31. Date filed (Month, Day, Year) JUL 21 2000		32. Registrar's Signature [Signature]					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23069

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James

Loftus

Sr.

2. Date of Death

July 20 2000

3. Time of Death

830 pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

235-14-9218

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 07, 1922

9. Birthplace (State or Foreign Country)

WV.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1865 Marshall Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6 yrs.

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Gauger

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

James Peter Loftus

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Blatner

19a. Informant's Name/Relationship (Type, Print)

Betty Jernigan daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3860 St. Andrews Ct. Mason, Ohio 45040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus

Date

July

20c. Location - City or Town, State

24,2000 Dundalk, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connolly Funeral Home of Dundalk, P.A.  
7110 Sollers Point Rd. Dundalk, Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Interstitial lung disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

congestive Heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RD 203398

29d. Date signed (Month, Day, Year)

July 20 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR AYSE GUL GOZU 9000 Franklin Square Drive Baltimore MD 21237

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

ORIGINAL

Loftus, James  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 000-0000.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1900-1901

1900-1901

1900-1901

1900-1901



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23070

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DELORES E. LAYTON

2. Date of Death

July 19 2000

3. Time of Death

1216

4a. Facility Name (If not institution, give street and number)

DORCHESTER GENERAL HOSPITAL

4b. City, Town, or Location of Death

CAMBRIDGE

4c. County of Death

DORCHESTER

Funeral  
Director

5. Social Security Number

212-30-0199

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

July 15, 1932

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md

10b. County

DORCHESTER

10c. City, Town or Location

CAMBRIDGE, Md. 21613

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

518 GLENBURN AVE

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

EDWARD BRIGGS

18. Mother's Name (First, Middle, Maiden Surname)

EMMA KIRTH

19a. Informant's Name/Relationship (Type, Print)

KIM SCHAFER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5518 RITTER AVE BALTO Md 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEM.

Date

7/24/00

20c. Location - City or Town, State

BALTIMORE Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME, CHTD.

7527 HARFORD RD. BALTO Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Gastrointestinal Bleed

Due to (or as a consequence of):

b.

Disseminated Intravascular Coagulation

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D 54656

29d. Date signed (Month, Day, Year)

07/18/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

P. F. TULL MD. Dorchester Hospital

CAMBRIDGE, MD. 21613

31. Date of Death (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23071

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frederick J. Leary

2. Date of Death

Month Day Year  
July 20, 2000

3. Time of Death

2:15 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

182-34-8354

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
09/18/1942

9. Birthplace (State or Foreign Country)

Darby, PA

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1703 Arabian Way

10f. Zip Code

21047

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Financial Advisor

16b. Kind of Business/Industry

J.J. Haines Co.

17. Father's Name (First, Middle, Last)

Eugene Leary

18. Mother's Name (First, Middle, Maiden Surname)

Mary L. Buehler

19a. Informant's Name/Relationship (Type, Print)

Mrs. Kaye Leary /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1703 Arabian Way Fallston, Maryland 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SS Peter &amp; Paul Cemetery

Date

07/25/00

20c. Location - City or Town, State

Springfield, PA

21. Signature of Funeral Service Licensee

Stephen D. Coster

MD1122

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PARKINSON DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

[Signature]

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

JULY 20, 2000 2:15 a.m.

FREDERICK LEARY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23072

AMENDED ITEM #17 PER FH G785 7/21/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Janie Bee McClellan				2. Date of Death Month Day Year 7 15 2000		3. Time of Death 2:45 a.m.		
	4a. Facility Name (If not institution, give street and number) Genesis Nursing Home				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 217-22-6647	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8-20-1907		9. Birthplace (State or Foreign Country) S.C.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 1606 Riggs Avenue			10f. Zip Code 21217		10g. Citizen of What Country? U S A			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laundry Worker			16b. Kind of Business/Industry Bugle Laundry			
	17. Father's Name (First, Middle, Last) John McCough McCULLOUGH				18. Mother's Name (First, Middle, Maiden Surname) Mary Cornwell				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Timothy McClellan- Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7522 Haystack Drive Randallstown, Md 21244					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Data 7-21-00		20c. Location - City or Town, State Randallstown, Md		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Hemorrhagic Cerebral vascular accident</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <i>Unknown</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial fib</i> <i>Pneumonia</i> <i>Diabetes</i>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> MD							
29c. License number 027564		29d. Date signed (Month, Day, Year) 7/18/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Allen Hettleman 1838 Greene Tree Rd #300</i>									
31. Date filed (Month, Day, Year) JUL 21 2000		32. Registrar's Signature <i>[Signature]</i> Sparks							

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 23073

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gloria G. Morris				2. Date of Death Month Day Year July 18 2000				3. Time of Death 0041				
	4a. Facility Name (If not Institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel				
Funeral Director	5. Social Security Number 577-22-0519		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) March 18, 1923		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent												
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Shady Side				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 6475 West Shady Side Road				10f. Zip Code 20764				10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Benjamin H. Goldstein						18. Mother's Name (First, Middle, Maiden Surname) Minnie Bast							
19a. Informant's Name/Relationship (Type, Print) Carl I. Morris (Husband)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6475 W. Shady Side Road, Shady Side, MD 20764							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 7/19/2000		20c. Location - City or Town, State Baltimore, MD					
21. Signature of Funeral Service Licensee Kumby S. R...						22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401							
23a. Pertinent: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>CANCER OF BREAST</u> Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 4.5 yrs			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier W. F. P...						29c. License number D08118			29d. Date signed (Month, Day, Year) 7/19/2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Rd. #300, Annapolis, MD 21401 Stanley P. Watkins, MD													
31. Date filed (Month, Day, Year) JUL 21 2000				32. Registrar's Signature [Signature]									





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23074

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard Michael McMahon, Sr.</b>				2. Date of Death Month Day Year <b>JULY 18 2000</b>		3. Time of Death <b>2:30 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH'S HOSPITAL</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>190-30-8685</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 9, 1938</b>		
	9. Birthplace (State or Foreign Country) <b>Ridgway, PA</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Upperco</b>		
Usual Residence of Decedent		10d. Inside City Limits <b>1 Yes 2 No</b>		10e. Street and Number <b>3 Hunt Lake Ct.</b>		10f. Zip Code <b>21155</b>			
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b>			
14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+) 5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Patent Attorney</b>		16b. Kind of Business/Industry <b>Law</b>			
17. Father's Name (First, Middle, Last) <b>Edward McMahon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Stegle</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Angela McMahon/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Hunt Lake Ct. Upperco, MD 21155</b>					
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>Beltsville, MD</b>		20d. Date <b>July 20 2000</b>			
21. Signature of Funeral Home Licensee <b>Michael J. Flagle</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MULTIPLE INJURIES</b>								Approximate Interval Between Onset and Death	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23c. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
24a. Was an autopsy performed? <b>1 Yes 2 No</b>								24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>				26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>				27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>	
28a. Date of Injury (Month, Day, Year) <b>7-18-00</b>				28b. Time of Injury <b>1338P M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred <b>MOTHER CAR DRIVEN OFF OF IMPACT WITH</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>I 83 BELTSVILLE BALTIMORE</b>				29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>	
29b. Signature and title of certifier <b>Walter Brelvi</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 19, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ADAMSON A. KORONOWSKI 111 Penn Street, Baltimore, Maryland 21201</b>								31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>	
32. Registrar's Signature <b>Sparks</b>								33. State Registrar <b>State Registrar</b>	

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23075

AMENDED ITEM #8 PER FH G785 7/21/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Albert W. Morgan Senior</b>						2. Date of Death Month <b>July</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>0840</b>		
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical Center</b>						4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>218-26-6013</b>		8. Sex <b>2</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>618 W. 36th Street</b>		10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Steel Company</b>		17. Father's Name (First, Middle, Last) <b>Arthur John Morgan</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Irene Lehnhoff</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Wannetta E. Stahl Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>618 W. 36th Street Baltimore, MD 21211</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore-Washington 7/19/00</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Fungemia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>July 17 2000</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>AU4176435A13044</b>	
29d. Date signed (Month, Day, Year) <b>July 17 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sean C. Atchison, D.O. 22 South Greene Street Baltimore, MD</b>		31. Data filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature 		State Registrar		10	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23076

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIAN DELLA NOACK</b>				2. Date of Death Month <b>JULY</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>1:38 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Carroll Co. General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>066-24-0421</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 10, 1930</b>	
	9. Birthplace (State or Foreign Country) <b>Buffalo N.Y.</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5313 Glen Falls Road</b>		10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>		16b. Kind of Business/Industry <b>Manufacturing</b>				
17. Father's Name (First, Middle, Last) <b>James Stamey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Randolph</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Deborah J. Brunner (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>644 Glynlee Court Reisterstown, Md. 21136</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>All Saints Cemetery</b>		Date <b>7/24/2000</b>		20c. Location - City or Town, State <b>Reisterstown, Md. 21136</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>CARCINOMA OF THE LUNG</b> Due to (or as a consequence of): <b>ADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MD				29c. License number <b>D51245</b>		29d. Date signed (Month, Day, Year) <b>JULY 19, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SAJID SHARIF CARROLL COUNTY GENERAL HOSPITAL - WESTMINSTER - MD</b>								
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature 						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 23077

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George M. Phillips Sr.

2. Date of Death

Month Day Year  
July 21, 2000

3. Time of Death

5:10 am

4a. Facility Name (If not institution, give street and number)

Manor Care Rossville

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-05-3972

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 24, 1916

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2032 Wareham Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck driver

16b. Kind of Business/Industry

Brewery

17. Father's Name (First, Middle, Last)

Charles V. Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Belle Bernhardt

19a. Informant's Name/Relationship (Type, Print)

George Phillips Jr. son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8217 Philadelphia Rd. Baltimore, Md. 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn Cemetery

Date

July

20c. Location - City or Town, State

25, 2000 Dundalk, Md.

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A.

7110 Sollers Point Rd, Dundalk, md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of bone

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45475

29d. Date signed (Month, Day, Year)

7/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Rahnama 17 Fontana Lane, Rosedale, Md 21237

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Benjamin Sparks

ORIGINAL

George Phillips 7/21/00 5:10 AM  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

 State of Maryland / Department of Health and Mental Hygiene **00 23078**  
 amend item 23a,b,c per phys. G785 7/21/00 yg  
 Certificate of Death

Reg. No.

 Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.
Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Alice Patterson</b>		2. Date of Death Month Day Year <b>June 30, 2000</b>		3. Time of Death <b>4:10pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Villa Nova Assistance Living</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>
5. Social Security Number <b>213-18-6379</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05-05-21</b>
9. Birthplace (State or Foreign Country) <b>MD</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6820 McClean Blvd.</b>			10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Line</b>		16b. Kind of Business/Industry <b>Signal Depot</b>	
17. Father's Name (First, Middle, Last) <b>Dock Mickey</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jenny Mickey</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Enger M. Martin</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3412 Chesterfield Avenue Baltimore, MD. 21213</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk. Cem.</b>		20c. Location - City or Town, State <b>07-06-2000 Arbutus, MD.</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Respiratory failure</b> Due to (or as a consequence of): b. <b>cardiovascular collapse Disease</b> Due to (or as a consequence of): c. <b>Cva Cerebral Vascular Disease</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>H31615</b>		29d. Date signed (Month, Day, Year) <b>July 3, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew Berkman DO 15 Walker Ave Balt MD 21208</b>					
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature 			

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23079

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel G. Raygor				2. Date of Death Month July Day 16, Year 2000				3. Time of Death 18:13			
	4a. Facility Name (If not institution, give street and number) 174 Jumpers Circle				4b. City, Town, or Location of Death Perry Hall				4c. County of Death Baltimore Co.			
Funeral Director	5. Social Security Number 216-30-7622		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) November 30, 1906		9. Birthplace (State or Foreign Country) Ashville, N.C.	
	Usual Residence of Decedent										10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Perry Hall				10g. Citizen of What Country? United States of America				
10e. Street and Number 174 Jumpers Circle				10f. Zip Code 21236				10g. Citizen of What Country? United States of America				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Keeper				16b. Kind of Business/Industry Goetz Meat Packing Co.				
17. Father's Name (First, Middle, Last) Nicholas B. Scanland						18. Mother's Name (First, Middle, Maiden Surname) Mary Virginia Durboraw						
19a. Informant's Name/Relationship (Type, Print) Ms. Betty Raygor / Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 174 Jumpers Circle Perry Hall, Maryland 21236						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		Date 7/19/00		20c. Location - City or Town, State Overlea, Maryland				
21. Signature of Funeral Service Licensee <i>Earl L. Raygor</i>						22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ATHEROSCLEROTIC CORONARY VASCULAR DISEASE YEARS Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death HOURS		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Myelodysplasia										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <i>Dr. Fernando J. Ferrao MD</i>						29c. License number D40480		29d. Date signed (Month, Day, Year) July 17, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO J. FERRAO MD 7672 BELAIR RD BALTO, MD 21236												
31. Date filed (Month, Day, Year) JUL 21 2000						32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23080

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAWRENCE SMALLWOOD</b>		2. Date of Death Month: <b>JULY</b> Day: <b>17</b> Year: <b>2000</b>		3. Time of Death <b>7:46 Am</b>
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>217-20-3149</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) <b>11-30-1910</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1924 E. Belvedere Ave</b>		10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>U.S.A</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12th grade</b> College (1-4 or 5+): <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Pharmacist</b>		16b. Kind of Business/Industry <b>Henryton State Hospital</b>
	17. Father's Name (First, Middle, Last) <b>George Albert</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth</b>		
	19a. Informant's Name/Relationship (Type, Print) - Son <b>J. Lawrence Smallwood Jr</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1924 E. Belvedere Avenue Baltimore, MD 21239</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. Location - City or Town, State <b>Arbutus, MD</b>
	21. Signature of Funeral Service Licensee <b>Flume H. Thompson Jr</b>		22. Name and Address of Facility <b>March F.H. West 4300 Wabash Avenue Baltimore, MD 21239</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RENAL FAILURE</b> <b>ANOXIC ENCEPHALOPATHY</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Dr. M. D.</b>		29c. License number <b>P 12555</b>		29d. Date signed (Month, Day, Year) <b>JULY, 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAMIN, ALIANA, M.D. GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BOULEVARD, BALTIMORE MD 21239-2495</b>					
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature <b>Denise Sparks</b>			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23081

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lindsey Allen Spear, Sr.

2. Date of Death

Month Day Year  
July 17 2000

3. Time of Death

540 PM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

232-30-2170

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 8, 1913

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1208 Fuselage Avenue

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Steel Mill

17. Father's Name (First, Middle, Last)

Bailey Spear

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Dexter Spear (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 Bourque Rd, Baltimore, Maryland 21220

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Mem. Gardens

Date

7/20/2000 Bel Air, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Gastroesophageal Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

11 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Physician☐ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Marco Zamora 9000 Franklin Square Drive Baltimore MD 21237

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Benita B Sparks

State  
Registrar

Black Mountain

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23082

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carroll Robinson Seay

2. Date of Death

July 18, 2000

3. Time of Death

10:48 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219-42-7512

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 9, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3803 Bayview Road

10f. Zip Code

21220

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1962 1964

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanical Millwright

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Leonard G. Seay, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marian Lillie Watters

19a. Informant's Name/Relationship (Type, Print)

Dixie Blotkamp - Seay (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3808 Bayview Road Middle River, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Camp Chapel U. M. C. Cem.

Date

7/21 2000

20c. Location - City or Town, State

White Marsh, Maryland

21. Signature of Funeral Service Licensee

Michael C. Seay

22. Name and Address of Facility

Brudzinski Funeral Home PA  
1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Clear Cell Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure, Hypertension

Liver Mediastinal Metastases

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sharratts MD

29c. License number

D 54 972

29d. Date signed (Month, Day, Year)

7/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. John Sharratts 9000 Franklin Square Drive Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Sharratts

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Seay, Carroll  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.




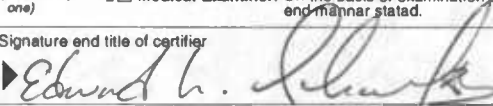

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23083

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSIE DEL SUMMERS</b>		2. Date of Death Month <b>JUL</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>7:00 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>		4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>
Funeral Director	5. Social Security Number <b>214-30-5740</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>May 4, 1933</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Ellicott city</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>8130 Main St</b>		10f. Zip Code <b>21043</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk.</b> College (1-4 or 5+) <b>College</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Bus Aide.</b>		16b. Kind of Business/Industry <b>Transportation</b>		
	17. Father's Name (First, Middle, Last) <b>Leonard Fischer</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Josie Louise Niser</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Billy Ray Summers</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8130 Main St Ellicott City, Maryland 21043</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Cemetery</b>		20c. Location - City or Town, State <b>Ellicott City, MD</b>
	21. Signature of Funeral Service Licensee  <b>MD1113</b>		22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. LUNG CANCER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>EMPHYSEMA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
State Registrar	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier  <b>Edward W. Schaefer MD.</b>		29c. License number <b>D18459</b>		29d. Date signed (Month, Day, Year) <b>JUL 19 2000</b>
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Edward W. Schaefer MD. 11055 LITTLE PATUX. PKWY COL. MD. 21044</b>				
	31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#3 per PhyG785 7/25/2000 EW

Certificate of Death

Reg. No.

00 23084

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie E. Schmedes

2. Date of Death

July 20,

2000

3. Time of Death

Unknown

4a. Facility Name (If not institution, give street and number)

6 Irving Place

4b. City, Town, or Location of Death

Pikesville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-74-9679

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 22, 1898

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

6 Irving Place

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James H. Hynson

18. Mother's Name (First, Middle, Maiden Surname)

Annie Ehm

19a. Informant's Name/Relationship (Type, Print)

Dolores R. Whitcomb Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2970 Summer Drive, Westminster, MD 21157

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National Cem.

Date

7/24/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

11824 Reisterstown Road

Eline Funeral Home Reisterstown, MD 21136

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

29c. License number

D 42561

29d. Date signed (Month, Day, Year)

7/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Passer, M.D. 21 Crossroads Dr #400 Owings Mills, MD 21117

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



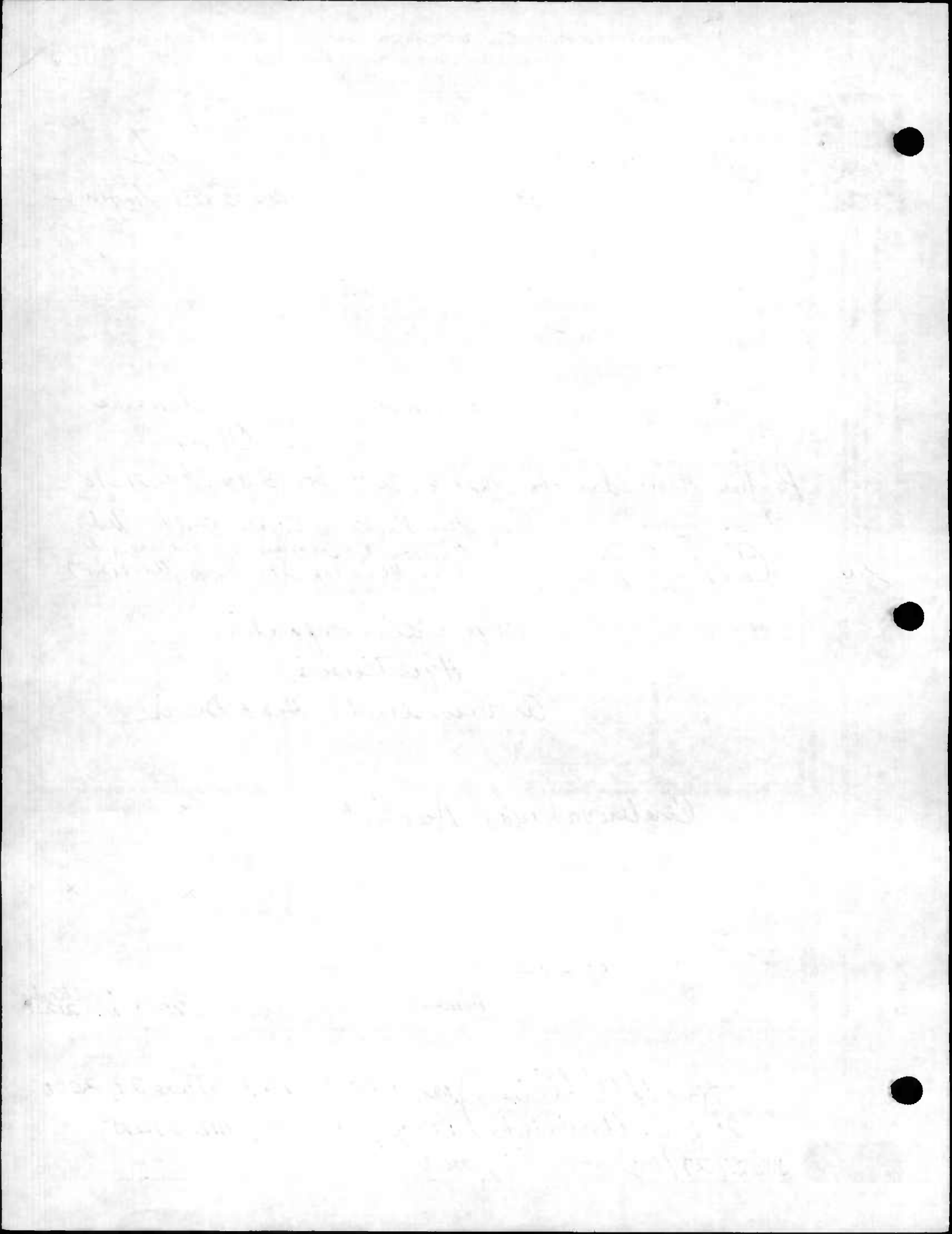
State of Maryland / Department of Health and Mental Hygiene 00 23085

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANNA Beatrice Spencer</b>						2. Date of Death Month <b>6</b> Day <b>29</b> Year <b>00</b>		3. Time of Death <b>0715</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNION MEMORIAL HOSP</b>						4b. City, Town, or Location of Death <b>BALTO.</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>239483727</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 22, 1931</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town, or Location <b>Balto.</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1621 E 30th St</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>US</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> Collegia (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>				16b. Kind of Business/Industry <b>domestic</b>			
	17. Father's Name (First, Middle, Last) <b>Clinton Moore</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Oliver</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Rubine Moore daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1621 E. 30th St. Balto. Md. 21218</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem Park July 6, 2000 Balto. Md.</b>		Data		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>Carlton C. Douglas</b>		22. Name and Address of Facility <b>Carlton C. Douglas Funeral Service 1701 McCulloch St. Balto. Md. 21217</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. <b>Myocardial Infarction</b>								Approximate Interval Between Onset and Death	
	Immediata Cause (Final disease or condition resulting in death) <b>Hypertension</b>									
	Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Atherosclerotic Heart Disease</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Cerebrovascular Accident</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>06 29 00</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1621 E. 30th MD 21218</b>					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <b>Dr. H. Williams, MD</b>				29c. License number <b>D00 55977</b>			29d. Date signed (Month, Day, Year) <b>June 29, 2000</b>		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>201 E. University Pkwy, Balto, MD 21218</b>									
	31. Data filed (Month, Day, Year) <b>JUL 21 2000</b>				32. Registrar's Signature <b>[Signature]</b>					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23086

6785

attended item #26.6 per md dated 7-26-00 wj

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY FRANCES SMITH

2. Date of Death

July 19, 2000

3. Time of Death

5:10 AM

4a. Facility Name (If not institution, give street and number)

4620 Forge Rd.

4b. City, Town, or Location of Death

Perry Hall

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-07-0438

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 19, 1917

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1006 Concordia Dr.

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Vice President

16b. Kind of Business/Industry

Charles T. Smith

Electrical Contractors

17. Father's Name (First, Middle, Last)

John J. Schaech

18. Mother's Name (First, Middle, Maiden Surname)

Wilhelmina Kidd

19a. Informant's Name/Relationship (Type, Print)

Mrs. Charlotte Klinefelter/dtr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4620 Forge Rd. Perry Hall, Md. 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Memorial

Date

7/22/00

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. KLATSKIN TUMOR (CARCINOMA OF BILE DUCT)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

daughter's home

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D34827

29d. Date signed (Month, Day, Year)

7/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES EBELING MD 7401 OSLER DRIVE SUITE 202 TOWSON MD 21204

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or date, located in the middle-left section of the page.

Handwritten text at the bottom of the page, appearing to be a date and possibly a name or title.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23087

AMENDED ITEM #1 PER MD G785 7/26/00 AH

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) VIOLA SCHROYER

2. Date of Death  
Month Day Year  
July 19, 20003. Time of Death  
10:09 AM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director5. Social Security Number  
395-03-20076. Sex  
☐ M ☒ F7. Age (In yrs. last birthday)  
84 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
Nov. 10, 19159. Birthplace (State or Foreign  
Country)  
Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8428 Alvin Road

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cafeteria Manager

16b. Kind of Business/Industry

A.A. Co. Board of Ed.

17. Father's Name (First, Middle, Last)

Charles

Waldahl

18. Mother's Name (First, Middle, Maiden Surname)

Ethel

Summy

19a. Informant's Name/Relationship (Type, Print)

Thelma Bensavage - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

328 Green Drive, Pasadena, MD 21122

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Glen Haven Cemetery

Date

July 22

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Stallings

22. Name and Address of Facility

Stallings Funeral Home, P.A.  
3111 Mountain Road, Pasadena, MD 2112223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

CARDIOMYOPATHY ISCHEMIC

Approximate  
Interval Between  
Onset and Death

30 months

Due to (or as a consequence of):

b.

atherosclerotic Cardiovascular Disease

30 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY EMBOLUS

6/20

HYPERTENSION.

MITRAL REGURGITATION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be  
☐ Suicide ☐ determined  
☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M. J. Sparks

29c. License number

D 21703

29d. Date signed (Month, Day, Year)

07/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL F. GARMY

FF. Smallwood Rd. Pasadena MD 21122

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

M. J. Sparks

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23088

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Amelia Block Trautman				2. Date of Death Month Day Year July 17 2000				3. Time of Death 4:45 PM		
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 208-32-5085		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	6. Date of Birth (Month, Day, Year) Aug 31, 1943		9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severn		
Usual Residence of Decedent											
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severn				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 1864 Montreal Road				10f. Zip Code 21144				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Stanley Joseph Block				18. Mother's Name (First, Middle, Maiden Surname) Amelia Beshenick							
19a. Informant's Name/Relationship (Type, Print) James J. Trautman (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1864 Montreal Road, Severn, MD 21144							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chartiers Cemetery				Date 07/21 2000		20c. Location - City or Town, State Carnegie, PA	
21. Signature of Funeral Service Licensee K. R. R. R.				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier K. R. R. R. MD				29c. License number D43477				29d. Date signed (Month, Day, Year) July 17 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amelia Block Trautman, 301 Hospital Drive, Glen Burnie MD 21061											
31. Date filed (Month, Day, Year) JUL 8 1 2000				32. Registrar's Signature A. R. R. R.							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #17,20B PER F.H. G785 7-28-00 **Certificate of Death**

Reg. No.

00 23089

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Anna Elinor Trebes

2. Date of Death

Month Day Year  
July 15 2000

3. Time of Death

1:50 am

4a. Facility Name (If not Institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

212-36-4450

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 26, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

n/a

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive Secretary

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

JOHN PETER BAUERNSCHUB

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Johanna Thom

John Peter Baurenschub

19a. Informant's Name/Relationship (Type, Print)

Elizabeth M. Amtmann/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

94 English Run Circle, Sparks, MD 21152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

7/18/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home  
10 W. Padonia Road, Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Signature and Title of certifier  
29c. License number  
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda, MD 2300 Dulaney Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Beverly Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

inmate Trebes, Anna



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23090

AMENDED ITEM #12 PER FH G785 7/21/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Fraser P Todd</i>		2. Date of Death Month Day Year <i>July 13 2000</i>		3. Time of Death <i>10:30 PM</i>		
	4a. Facility Name (If not institution, give street and number) <b>St. Joseph Hospital</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>164-18-6528</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b>		
	8. Date of Birth (Month, Day, Year) <b>July 21 1919</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>				
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Phoenix</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2409 Stanwick Road</b>			10f. Zip Code <b>21131</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>48-52</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Manager</b>		16b. Kind of Business/Industry <b>Heavy Equipment</b>		
17. Father's Name (First, Middle, Last) <b>George Porter Todd</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Madeline May Fraser</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Blake H. Todd/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>825 Branford Cir., Lutherville, MD 21093</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens Timonium, MD</b>		20c. Location - City or Town, State <b>7/18/00</b>			
21. Signature of Funeral Service Licensee <i>Michael J. Flagle</i>			22. Name and Address of Facility <b>Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093</b>				
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Arteriosclerotic Cardio Vascular Disease</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29f. Signature and title of certifier <i>Michael J. Flagle</i>					
		29g. License number <b>09383</b>		29d. Date signed (Month, Day, Year) <b>July 14 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Charles F. O'Donnell MD</i> <b>111 Hamlet Hill Rd Baltimore MD 21210</b>							
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature <i>James B. Sparks</i>					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23091

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Twinkle Starr Vanderbilt

2. Date of Death

Month Day Year  
July 16 2000

3. Time of Death

10:00 PM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

151-42-5749

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9-6-48

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4 Parham Circle Apt. 2C

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Paul Vanderbilt

18. Mother's Name (First, Middle, Maiden Surname)

Dora Labar

19a. Informant's Name/Relationship (Type, Print)

Melody VanDoren/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Parham Circle, Apt. 2C, Baltimore, MD 21237

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

7-19-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cvach/Rosedale Funeral Home  
1211 Chesaco Avenue, Baltimore, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Zayd Eldadah Physician

29c. License number

D0054303

29d. Date signed (Month, Day, Year)

July 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zayd Eldadah, MD 9000 Franklin Square Drive Baltimore, Maryland 21237

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Zayd Eldadah

Vanderbilt, Twinkle  
Baltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21268-0760To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23092

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Walch

2. Date of Death

Month Day Year  
July 16 2000

3. Time of Death

9:25 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare Franklin Woods

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219 34 4971

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 16 1911

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8819 Spring Road

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson &amp; Seamstress

16b. Kind of Business/Industry

Lohman's Department Store

17. Father's Name (First, Middle, Last)

George P.C. Rumpf

18. Mother's Name (First, Middle, Maiden Surname)

Katherine T Lucas

19a. Informant's Name/Relationship (Type, Print)

Carolyn Clark (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5266 Millfield Road Baltimore, Maryland 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery July 20, 2000

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kathleen Joseph Chynoweth

22. Name and Address of Facility

Lassahn Funeral Home Inc  
7401 Belair Road Baltimore, Maryland 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Regurey MD

29c. License number

D 53720

29d. Date signed (Month, Day, Year)

07/19/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Regurey 2112 Belair Road, Suite 9, Fallston, MD 21047

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

S. Regurey

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


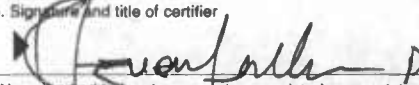
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Nona Vernice Olgie Milligan</b>		2. Date of Death Month <b>July</b> Day <b>17</b> , Year <b>2000</b>		3. Time of Death <b>3:57pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>		4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>274-32-9349</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months _____ Days _____	If Under 24 Hrs. Hours _____ Min. _____	8. Date of Birth (Month, Day, Year) <b>April 13, 1916</b>
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>Ohio</b>			
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Takoma Park</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number <b>412 Ethan Allen Ave</b>		10f. Zip Code <b>20912</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4or 5+) <b>4</b>			
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>			
17. Father's Name (First, Middle, Last) <b>Harry Nelson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Goldie "Unknown"</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mohamed Sangare/ Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2900 14th St. NW Washington, DC 20009</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Deerfield Cemetery</b>		20c. Location - City or Town, State <b>07/22/00 Morgan Co, Ohio</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Takoma Funeral Home 254 Carroll St. NW Washington, DC 20012</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Coronary Artery Disease</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) _____		28b. Time of Injury _____ M _____	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>H36078</b>		29d. Date signed (Month, Day, Year) <b>7-17-00</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>STEVEN FULLER 7600 Carroll Ave, Takoma Park, MD 20912</b>					
31. Date filed (Month, Day, Year) <b>JUL 21 2000</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23094

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD WALTON SR.

2. Date of Death  
Month Day Year  
JULY 18 20003. Time of Death  
19:55

4a. Facility Name (If not institution, give street and number)

HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

HAVRE DE GRACE

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

255-16-2516

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB 15 1923

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

ABERDEEN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

48 LIBERTY STREET

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1940/68

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

CHAUFFEUR

16b. Kind of Business/Industry

MILITARY

17. Father's Name (First, Middle, Last)

RICHARD WALTON

18. Mother's Name (First, Middle, Maiden Surname)

LEANNA MORGAN WALTON

19a. Informant's Name/Relationship (Type, Print)

Carolyn J. Giles/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

61 Swan Street, Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARFORD MEMORIAL GARDENS

Date

7-24-00

20c. Location - City or Town, State

ABERDEEN, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA  
321 S PHILADELPHIA BLVD ABERDEEN, MD 21001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANCER of STOMACH w METASTASIS  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- HYPERTENSION

- DIABETES

- RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

1942800

29d. Date signed (Month, Day, Year)

7/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Biondo MD 314 S. Union St. Apt 6, Md 21078

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 23095

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES PATRICK ANGLIM</b>				2. Date of Death Month Day Year <b>JULY 6, 2000</b>		3. Time of Death <b>10:00</b>	
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Pr. Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>157-26-4196</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 10, 1936</b>	
	9. Birthplace (State or Foreign Country) <b>CT</b>		10a. State <b>NJ</b>		10b. County <b>Middlesex</b>		10c. City, Town or Location <b>Avenel</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>15 Burnett Street</b>		10f. Zip Code <b>07001</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1956-58</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Quality Assurance Eng.</b>				16b. Kind of Business/Industry <b>U.S. Government</b>		17. Father's Name (First, Middle, Last) <b>George Anglim</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Anne Clarke</b>				19a. Informant's Name/Relationship (Type, Print) <b>George K. Anglim/Brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1900 Misty Harbour Cir. League City, TX</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Graceland Mem. Cem.</b>		20c. Location - City or Town, State <b>7/11/00 Kenilworth, N.J.</b>		21. Signature of Funeral Service Licensee 	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CANCER</b> Due to (or as a consequence of): <b>b. COLON CANCER</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>APPROX. 4 MONTHS</b> <b>APPROX. 4 MONTHS</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D50853</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>7-6-2000</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. GYAN SURANA, MD DEALE, MARYLAND, 20751</b>			
	31. Date filed (Month, Day, Year) <b>JUL 07 2000</b>				32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

100 S D 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23096

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEWELL WEBB BELLAMY

2. Date of Death

July 10 2000

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

22680 Cedar Lane Crt. #1314

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

227-22-4767

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 6, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Leonardtwn

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22680 Cedar Lane Crt. #1314

10f. Zip Code

20650

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
516a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Henry Webb

18. Mother's Name (First, Middle, Maiden Surname)

Victoria MacMillan Webb

19a. Informant's Name/Relationship (Type, Print)

Jessalyn Swann/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 646 Mechanicsville, MD 20659

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brinsfield-Echols Crem. 7/14/00 Charlotte Hall

Date

20c. Location - City or Town, State

MD.

21. Signature of Funeral Service Licensee

David C. Echols M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.  
P.O. BOX 567 LA PLATA, MD. 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END-STAGE RENAL FAILURE

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

V. Anmangandla

29c. License number

D26064

29d. Date signed (Month, Day, Year)

7-10-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. Anmangandla, M.D. P.O. Box 282 Charlotte Hall, MD. 20622

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2024.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23097

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE ALFRED BROWN

2. Date of Death

Month Day Year

July 11, 2000

3. Time of Death

7:00 PM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

218-28-7638

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 15, 1932

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

INDIAN HEAD

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4110 G.W.Y. &amp; N BROWN PLACE

10f. Zip Code

20640

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

Yes ☒ No ☐

If Yes, Give Year or Dates:

1953-

1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LEAD MAN

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

JAMES FRANCIS BROWN

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA THERESA GWYNN BROWN

19a. Informant's Name/Relationship (Type, Print)

MARGO BROWN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3124 BRINKLEY ROAD, #201, TEMPLE HILLS, MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. CHARLES CEMETERY

Date

7/15/00

20c. Location - City or Town, State

GLYMONT, MARYLAND

21. Signature of Funeral Service Licensee

LUDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Mycobacterium Avium infection

Due to (or as a consequence of):

b. Lung abscess, cavitation

Due to (or as a consequence of):

c. Paralysis

Due to (or as a consequence of):

d. Vertebral Abscess

Approximate Interval Between Onset and Death

2 yrs

1 month

2 weeks

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Chronic pancreatitis, gastritis.

meningitis, hematuria,

Chronic obstructive pulmonary Dis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 08370

29d. Date signed (Month, Day, Year)

7/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul E. Pritchett, MD 118 La Grange Ave. P.O.Box 1317, La Plata, Maryland 20646

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23c-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Lawrence A. Brown



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23098

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Elizabeth Brushé</b>				2. Date of Death Month <b>July</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>2:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center at GBMC</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>219-30-5691</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Nov. 15, 1934</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Harford</b>	10c. City, Town or Location <b>Edgewood</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10a. Street and Number <b>1834 John Drive</b>			10f. Zip Code <b>21040</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>School Librarian</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Private Education</b>		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) <b>Lawrence Thomas Holden</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Schafer</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>James W. Brushé, Sr. / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1834 John Drive, Edgewood, MD 21040</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Louden Park Cemetery</b>		20c. Location - City or Town, State <b>7-6-00 Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <b>cardiorespiratory arrest</b> Due to (or as a consequence of): b. <b>liver failure</b> Due to (or as a consequence of): c. <b>pancreatic CA</b> Due to (or as a consequence of): d.							<b>3 mo</b>  <b>one month</b>  <b>no year</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <b> Hospice</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D39099</b>		29d. Date signed (Month, Day, Year) <b>7/3/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. W. Williams, MD GBMC HOSPICE, BALTIMORE 21204</b>								
31. Date filed (Month, Day, Year) <b>JUL 5 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL



Handwritten text, possibly a signature or name, located in the upper right quadrant.

Handwritten text, possibly a date or a short note, located in the center of the page.

X

X

Handwritten text, possibly a name or word, located in the lower left quadrant.

Handwritten text, possibly a signature or name, located in the lower right quadrant.

Handwritten text, possibly a date or a short note, located at the bottom of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23099

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARLIN LEROY BACON</b>				2. Date of Death Month Day Year <b>JULY 7, 2000</b>				3. Time of Death <b>3:05 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON COUNTY HOSPITAL</b>				4b. City, Town, or Location of Death <b>HAGERSTOWN</b>				4c. County of Death <b>WASHINGTON</b>	
Funeral Director	5. Social Security Number <b>199-07-1252</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 22, 1917</b>		9. Birthplace (State or Foreign Country) <b>Robertson, Iowa</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>PA</b>		10b. County <b>Franklin</b>		10c. City, Town or Location <b>Waynesboro</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>203-B Elder Avenue</b>				10f. Zip Code <b>17268</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>manager</b>			16b. Kind of Business/Industry <b>theater</b>		
	17. Father's Name (First, Middle, Last) <b>Royal B. Bacon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Howard Bacon</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>502 N Holly ST Medford Oregon 97051-2419</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Umberland Valley Crematorium</b>		20c. Date <b>7/10</b>		20d. Location - City or Town, State <b>Waynesboro PA 17268</b>			
	21. Signature of Funeral Service Licensee <b>James E. Bowersox</b>				22. Name and Address of Facility <b>Grove-Bowersox Funeral Home, Inc. 50 S Broad ST Waynesboro PA 17268</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE INJURIES</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>7-7-00</b>		28b. Time of Injury <b>2 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>DRIVEN OFF PICKUP, IMPACT WITH ANOTHER</b>	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Wayne Bowersox</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 8, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARLON A. KOBEL MD 111 Penn Street, Baltimore, Maryland 21201</b>									
	31. Date filed (Month, Day, Year) <b>JUL 11 2000</b>		32. Registrar's Signature <b>Benjamin B. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 23a,b,c per phys. G785, State of Maryland / Department of Health and Mental Hygiene  
 amended item #7 per anatomy board g784 6/30/00 ah

Certificate of Death

Reg. No.

00 23100

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Earl Miller Beardsley

2. Date of Death

Month Day Year  
JUNE 27, 2000

3. Time of Death

2:00 P.M.

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

577-26-7325

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

~~74~~ 75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 21, 1924

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

532-E Alabama Avenue

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No '51-53  
If Yes, Give Year or Dates: '42-46,

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

physician

16b. Kind of Business/Industry

hospital

17. Father's Name (First, Middle, Last)

Irvin L. Beardsley

18. Mother's Name (First, Middle, Maiden Sumame)

Charlotte Freeman

19a. Informant's Name/Relationship (Type, Print)

VA MD Health Care System

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Bldg 361 Perry Point, MD 21902

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ~~CARDIAC ARREST~~ PROBABLE ASPIRATION PNEUMONIA

MINUTES

Due to (or as a consequence of):

CARDIOPULMONARY FAILURE

b. Due to (or as a consequence of):

CARDIAC ARREST

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

PEPTIC ULCER DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19177

29d. Date signed (Month, Day, Year)

JUNE 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EAPEN ABRAHAM, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

*Benjamin Sparks*

NAME KNOWN TO PHYSICIAN:  
EARL MILLER BEARDSLEY  
Baltimore, Maryland 21215-6020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 23101

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARJORIE MAY BICKEL

2. Date of Death

Month Day Year  
JULY 7, 2000

3. Time of Death

6:20 p.m.

4a. Facility Name (If not institution, give street and number)

3615 Avocado Road

4b. City, Town, or Location of Death

Port Republic

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

216 22 0773

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 22, 1911

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Port Republic

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3615 Avocado Road

10f. Zip Code

20676

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Writer

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Frank Salathiel Hannen

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Moore

19a. Informant's Name/Relationship (Type, Print)

George Louis Bickel / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3615 Avocado Road, Port Republic, Maryland 20676

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

07/08/00

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Charles F. Bickel

22. Name and Address of Facility

Rausch Funeral Home, P.A.

4405 Broomes Island Road, Port Republic, MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d. Hyperlipidemia

Approximate  
Interval Between  
Onset and Death

unt

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. M. Brooks, M.D.

29c. License number

D39920

29d. Date signed (Month, Day, Year)

7-8-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. M. Brooks, M.D., Suite 111, 110 Hospital Drive, Prince Frederick, Maryland 20678

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CHILDS, LBS

100 lbs

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23102

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roland Howell Carman				2. Date of Death Month Day Year June 29 2000		3. Time of Death 1525	
	4a. Facility Name (If not Institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 218-10-3402		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 27 1919	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1101 Yorkshire Way		10f. Zip Code 21158		10g. Citizen of What Country? United States		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Self-employed				
17. Father's Name (First, Middle, Last) William Howell Carman				18. Mother's Name (First, Middle, Maiden Surname) Edna Ruth Freedenburg				
19a. Informant's Name/Relationship (Type, Print) Ruth C. Gilvickas Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 Yorkshire Way Westminster, MD 21158				
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery		20c. Location - City or Town, State 7/3/2000 Woodlawn, Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary hemorrhage Due to (or as a consequence of): b. Lung abscess with erosion through bronchus Due to (or as a consequence of): c. Mycetoma Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death days years		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D0044362		29d. Date signed (Month, Day, Year) June 30, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ENRICO A. GIANGERUSO, MD 200 MEMORIAL AVE WESTMINSTER								
31. Date filed (Month, Day, Year) JUL 05 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23103

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Magdalen A. Charles

2. Date of Death

Month Day Year  
July 3 2000

3. Time of Death

2:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1701 Bennett Rd.

4b. City, Town, or Location of Death

Eldersburg

4c. County of Death

Carroll

5. Social Security Number

412-28-3836

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 10, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1701 Bennett Rd.

10f. Zip Code

21784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her Household

17. Father's Name (First, Middle, Last)

Winfield Scott Powell

18. Mother's Name (First, Middle, Maiden Surname)

Berta B. Spradling

19a. Informant's Name/Relationship (Type, Print)

Raymond Beaty (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1701 Bennett Rd. Eldersburg, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mount Olive Cemetery

Date

7/5/00

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burrier-Queen Funeral Directors, PA

1212 West Old Liberty Rd. Winfield, MS 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Carcinoma of the lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0020964

29d. Date signed (Month, Day, Year)

July 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23104

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Lee Corey

2. Date of Death

Month Day Year  
July 3, 2000

3. Time of Death

11:50 PM

4a. Facility Name (If not institution, give street and number)

3320 Forge Hill Road

4b. City, Town, or Location of Death

Street

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

577-40-2827

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 6, 1933

9. Birthplace (State or Foreign Country)

Samoa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Street

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3320 Forge Hill Rd.

10f. Zip Code

21154

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Joseph (u/k) Ardeeser

18. Mother's Name (First, Middle, Maiden Surname)

Madeline (u/k) Rae

19a. Informant's Name/Relationship (Type, Print)

Emery M. Corey / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3320 Forge Hill Rd., Street, MD 21154

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Clarks U.M. Cemetery

Date

7-7-00

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ADENOCARCINOMA, LUNG, METASTATIC

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 08096

29d. Date signed (Month, Day, Year)

JULY 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWAKOWSKI MD

125 N. MAIN ST. BELAIR, MD 21014

31. Date filed (Month, Day, Year)

2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
00202.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23105

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEAH BORNEMANN COLBERT</b>						2. Date of Death Month Day Year <b>July 3, 2000</b>		3. Time of Death <b>2:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>						4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>213-01-1011</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12/15/1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>108 Idlewild Road</b>				10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retail Management</b>			16b. Kind of Business/Industry <b>Clothing</b>			
17. Father's Name (First, Middle, Last) <b>George Edward Bornemann</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Victorine DuPont Butler</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sandra L. Borneman/Niece</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>124D Walton Road Abingdon, Md. 21009</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Lawn Mem. Park 2000</b>			20c. Location - City or Town, State <b>Los Angeles, CA.</b>		Date <b>7/11</b>		
21. Signature of Funeral Service Licensee <b>M. Blackler Kurtz III</b>			22. Name and Address of Facility <b>E.G. Kurtz &amp; Son Funeral Home, P.A. Jarrettsville, Maryland</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>pneumonia.</b> Due to (or as a consequence of): <b>Dehydration</b> Due to (or as a consequence of): <b>Arterio Sclerotic Cardiovascular disease</b> Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>J. Lee M.D.</b>		29c. License number <b>D20661</b>		29d. Date signed (Month, Day, Year) <b>7/3/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Lee M.D. 669 Revolution St. Havre de Grace MD. 21078</b>										
31. Date filed (Month, Day, Year) <b>JUL 7 2000</b>		32. Registrar's Signature <b>B. Sparks</b>								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23106

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruby Pauline Clark</b>						2. Date of Death Month Day Year <b>July 7, 2000</b>		3. Time of Death <b>2320</b>	
	4a. Facility Name (If not institution, give street and number) <b>61 Baker Street</b>						4b. City, Town, or Location of Death <b>Aberdeen</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>236-22-1130</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 7, 1923</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>61 Baker Street</b>				10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>In home</b>			
17. Father's Name (First, Middle, Last) <b>Robert F. Wheelock</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Sallie C. Cornett</b>				
19a. Informant's Name/Relationship (Type, Print) <b>William R. Clark (Spouse)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>61 Baker Street, Aberdeen, Maryland 21001</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Gardens</b>		Date <b>7/12/00</b>		20c. Location - City or Town, State <b>Aberdeen, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Kenneth B. Cargo</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>						
23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>pancreatic CA with liver metastasis</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death <b>Weeks</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- DIABETES</b> <b>- GANGRENE of FOOT.</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>T. Brando mps</b>				29c. License number <b>D42800</b>		
29d. Date signed (Month, Day, Year) <b>7/8/00</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THOMAS BRANDO MD 319 S. UNION AVE., HARBOR, MD 21078</b>						
31. Date filed (Month, Day, Year) <b>JUL 10 2000</b>				32. Registrar's Signature <b>P. Sparks</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



ADH

LISA CARPENTER

00-3608-037 AMEND ITEMS: #23 PART I, 27 PER MEO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23107

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 25a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

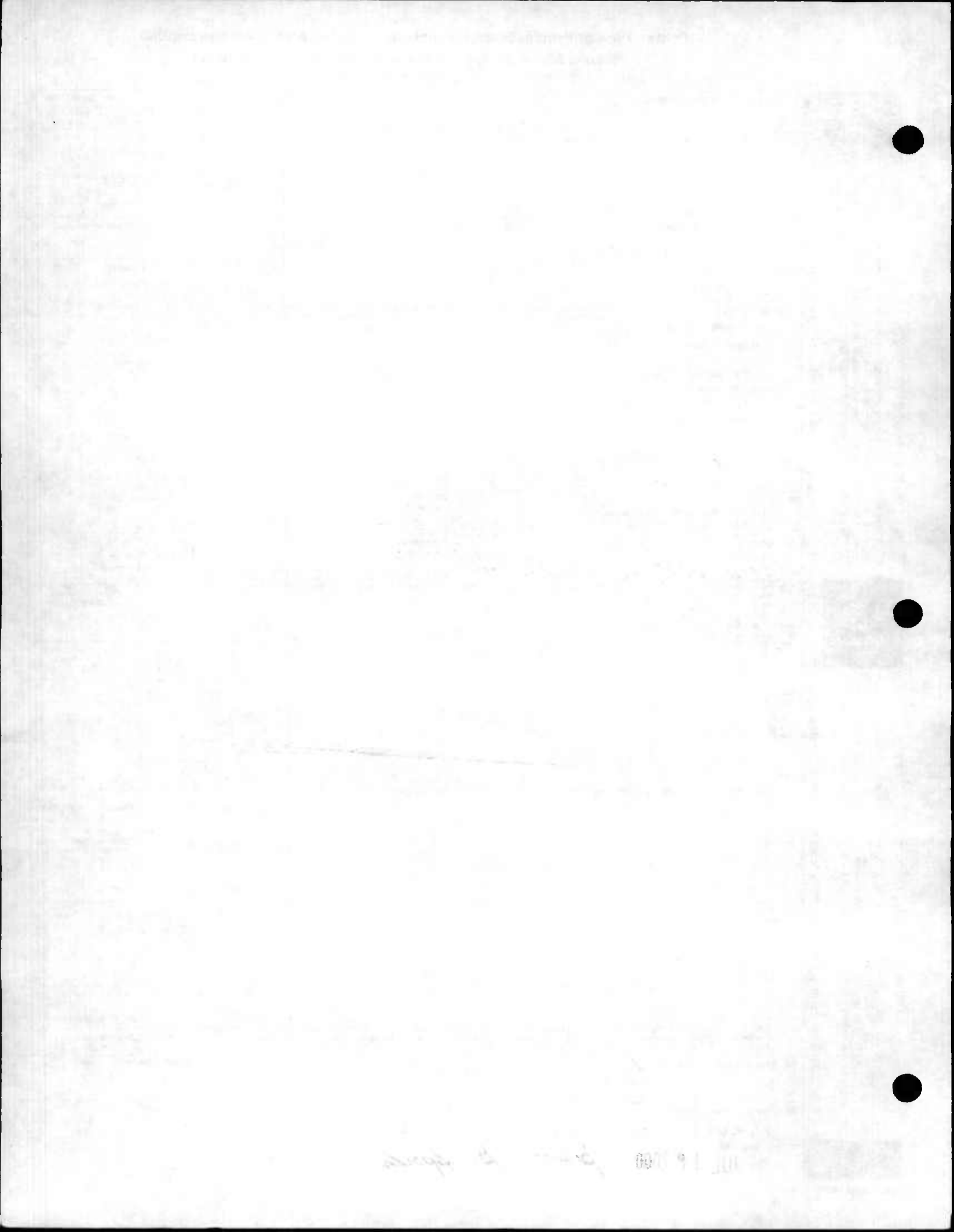
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Lisa Ann Carpenter</b>		2. Date of Death Month <b>JUNE</b> Day <b>30</b> , Year <b>2000</b>		3. Time of Death <b>1420 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>22795 GODDARD COURT</b>			4b. City, Town, or Location of Death <b>LEONARDTOWN</b>		4c. County of Death <b>ST. MARY'S</b>
5. Social Security Number <b>019-489-043</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>42</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>March 27, 1958</b>			9. Birthplace (State or Foreign Country) <b>Florida</b>		
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Leonardtown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>22795 Goddard Court # 43</b>			
10f. Zip Code <b>20650</b>		10g. Citizen of What Country? <b>U S A</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (14 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Mark Robinson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Carol McGuinness</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Laurie S. Brown (Sister)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1425 West Lake Mary Blvd., Lake Mary, Florida 32746</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>7/12/2000 Alexandria, Virginia</b>	
21. Signature of Funeral Service Licensee <i>Michael Kevin Henderson</i>			22. Name and Address of Facility <b>Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARDIAC ARRHYTHMIA DUE TO HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JULY 1, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JUL 18 2000</b>		32. Registrar's Signature <i>[Signature]</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23108

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>MARGARET LOUISE DAVIS</b>						2. Date of Death Month Day Year <b>JULY 02 2000</b>			3. Time of Death <b>6:15AM</b>		
4a. Facility Name (If not institution, give street and number) <b>MARINER HEALTH OF FOREST HILL</b>						4b. City, Town, or Location of Death <b>FOREST HILL</b>			4c. County of Death <b>HARFORD</b>		
5. Social Security Number		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Dec. 6, 1913</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>											
Usual Residence of Decedent											
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Fallston</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <b>3217 Ascot Lane</b>						10f. Zip Code <b>21047</b>			10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)						18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>John N. Jones</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Maggie L. Jones</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Wilson S. Davis, Jr. - Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3217 Ascot Lane, Fallston, Maryland 21047</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>				Date <b>7/6/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Director 						22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>dehydration</u> Due to (or as a consequence of):  b. <u>progressive atherosclerosis</u> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 						29c. License number <b>D 32295</b>			29d. Date signed (Month, Day, Year) <b>July 2, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wilson S. Davis, Jr. 3217 Ascot Lane, Fallston, MD 21047</b>											
31. Date filed (Month, Day, Year) <b>JUL 5 2000</b>		32. Registrar's Signature 									

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23109

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Martha E. Davis</i>				2. Date of Death Month Day Year <i>July 2 2000</i>		3. Time of Death <i>2019</i>
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Hospital Baltimore</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>
Funeral Director	5. Social Security Number <i>217-30-2067</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>66</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>October 3, 1933</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent						
10a. State <i>Maryland</i>		10b. County <i>Washington</i>		10c. City, Town or Location <i>Clear Spring</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>13073 Independence Road</i>				10f. Zip Code <i>21722</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>supervisor</i>		16b. Kind of Business/Industry <i>grocery</i>	
17. Father's Name (First, Middle, Last) <i>Steward A. Ramsburg</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Della F. Keller</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Richard E. Davis - husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>13073 Independence Rd., Clear Spring, Md. 21722</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Cedar Lawn Memorial Park</i>		Date <i>7-6-00</i>		20c. Location - City or Town, State <i>Hagerstown, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Scott M. Minnick</i>				22. Name and Address of Facility <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Heart failure, sepsis</i> Due to (or as a consequence of): <i>b. Ur sepsis</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Michael Shumway</i>				29c. License number <i>UMH# 13088</i>		29d. Date signed (Month, Day, Year) <i>7/2/2,000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>University of Maryland; 22 S. Green St. Baltimore 21201</i>							
31. Date filed (Month, Day, Year) <i>JUL 10 2000</i>		32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23110

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Elizabeth Dollard

2. Date of Death

July 5 2000

3. Time of Death

4:37 A.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-16-4346

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 24, 1911

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

White Marsh

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11614 Jerome Avenue

10f. Zip Code

21162

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner and Operator

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

William (UNK) Lufrio

18. Mother's Name (First, Middle, Maiden Surname)

Lena (NMN) Severt

19a. Informant's Name/Relationship (Type, Print)

Cindy L. Derickson/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11614 Jerome Ave., POB 114, Upper Falls, MD 21156

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

7/7/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen A. Neugebauer

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Yvonne Latimer MD RD 203471

29c. License number

29d. Date signed (Month, Day, Year)

07/05/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Yvonne Latimer 9000 Franklin Square Drive Baltimore, MD 21237

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 7 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner



Calvin Hezekiah Damron Jr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27,28a,b,c,d,e,f per me G788 10/5/00 yf **Certificate of Death**

Reg. No.

00 23111

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Calvin Hezekiah Damron, Jr.</b>				2. Date of Death Month <b>July</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>09:30 A.M.</b>	
	4e. Facility Name (If not institution, give street and number) <b>2649 Schultz Place</b>				4b. City, Town, or Location of Death <b>Waldorf</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>217-57-2028</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>3</b> Months <b>9</b> Days <b>9</b>		8. Date of Birth (Month, Day, Year) <b>April 5, 2000</b>	
	9. Birthplace (State or Foreign Country) <b>Clinton Maryland</b>							
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Waldorf</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2649 Schults Place</b>				10f. Zip Code <b>20602</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>			16b. Kind of Business/Industry <b>N/A</b>	
17. Father's Name (First, Middle, Last) <b>Calvin Hezekiah Damron</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Brandy Haynes</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Calvin H. Damron (Father)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2649 Sxhults Place Waldorf, Maryland 20602</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>July 18 2000</b>		20c. Location - City or Town, State <b>Suitland Maryland</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton MD 20735</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. SUDDEN UNEXPLAINED DEATH IN INFANCY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found 7/14/00</b>		28b. Time of Injury <b>found 9:00 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>unknown</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>unknown</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>July 15, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>JUL 20 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23112

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gayle Elise Fischer						2. Date of Death Month Day Year July 2 2000		3. Time of Death 2:40pm	
	4a. Facility Name (If not institution, give street and number) 1299 Naugahyde Road						4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 212-40-7107		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Oct 5 1942		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 1299 Naugahyde Road				10f. Zip Code 21157		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Day Care Operator			16b. Kind of Business/Industry Own Business			
17. Father's Name (First, Middle, Last) John Butler Williams						18. Mother's Name (First, Middle, Maiden Surname) Anne Kinsey				
19a. Informant's Name/Relationship (Type, Print) Gordon Fischer, Jr/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1299 Naugahyde Rd Westminster, MD 21157						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Mem Pk		Date 7/6		20c. Location - City or Town, State Sykesville, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 6 mo
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D35 398		29d. Date signed (Month, Day, Year) 7-3-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter, MD 224 Washington Heights, Westminster, MD 21157										
31. Date filed (Month, Day, Year) JUL 06 2000		32. Registrar's Signature 								



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Henry Thomas Fields, Jr.</u>				2. Date of Death Month <u>07</u> Day <u>02</u> Year <u>2000</u>		3. Time of Death <u>1820</u>	
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical System</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>217-30-5195</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>64</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Apr 9 1936</u>	
	9. Birthplace (State or Foreign Country) <u>MD</u>		10a. State <u>MD</u>		10b. County <u>Carroll</u>		10c. City, Town or Location <u>Westminster</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>2307 Coon Club Road</u>		10f. Zip Code <u>21157</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Maintenance</u>		16b. Kind of Business/Industry <u>Bethlehem Steel Co</u>				
17. Father's Name (First, Middle, Last) <u>Henry T. Fields Sr</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Edna Forster</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Richard C. Fields/Son</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3124 Littlestown Pike Westminster, MD 21158</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Evergreen Memorial</u>		Date <u>7/7</u>		20c. Location - City or Town, State <u>Finksburg, MD</u>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <u>Pritts Funeral Home and Chapel</u> <u>412 Washington Rd Westminster, MD 21157</u>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Falminent Hepatic Failure</u> Due to (or as a consequence of):  b. <u>Hepatic Neoplasm</u> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  , MD		29c. License number <u>P13115</u>		29d. Date signed (Month, Day, Year) <u>7/2/00</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Lance Uradomo, 22 S. Green St. Baltimore MD 21201</u>								
31. Date filed (Month, Day, Year) <u>JUL 07 2000</u>		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23114

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Katherine Anna Flowers</b>					2. Date of Death Month Day Year <b>July 07 2000</b>			3. Time of Death <b>2:10</b>	
	4a. Facility Name (If not institution, give street and number) <b>Citizens Care Center</b>					4b. City, Town, or Location of Death <b>Havre de Grace</b>			4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>212-18-2331</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 02, 1913</b>		9. Birthplace (State or Foreign Country) <b>Belcamp, MD</b>	
	Usual Residence of Decedent					10c. City, Town or Location <b>Aberdeen</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Harford</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 years</b>		College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Head Housekeeper</b>		16b. Kind of Business/Industry <b>Sanitorial</b>			
	17. Father's Name (First, Middle, Last) <b>William Lauterbach</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Hohlein</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>David W. Eldreth</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>413 Cedar Springs Road Bel Air, MD 21015</b>				
To Be Completed by Physician/Medical Examiner	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baker's Cemetery</b>		Date <b>07-12-00</b>		20c. Location - City or Town, State <b>Aberdeen, MD</b>			
	21. Signature of Funeral Service Licensee <b>Kenneth B. Bango</b>					22. Name and Address of Facility <b>ABERDEN, MARYLAND 21001-3399 Tarring-Cargo Funeral Home</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ALZHEIMERS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>ALZHEIMERS</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>Years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- MYOCARDIAL INFARCTION</b> <b>- ANEMIA</b> <b>- CONGESTIVE HEART FAILURE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>T. Biondo MD</b>		29c. License number <b>142800</b>		29d. Date signed (Month, Day, Year) <b>7/8/00</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>T. Biondo MD 319 S. UNION AVE. HMD, MD. 21078</b>		
31. Date filed (Month, Day, Year) <b>JUL 10 2000</b>		32. Registrar's Signature <b>B. Sparks</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

20

State  
Registrar



1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

2. The second part of the document is a series of handwritten notes or entries. These are written in a cursive script and are organized into paragraphs. The notes appear to be a continuation of the record or a separate set of observations.

3. The third part of the document is a series of handwritten notes or entries, similar to the second part. These are also written in a cursive script and are organized into paragraphs.

4. The fourth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into paragraphs.

5. The fifth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into paragraphs.

6. The sixth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into paragraphs.

7. The seventh part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into paragraphs.

8. The eighth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into paragraphs.

9. The ninth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into paragraphs.

10. The tenth part of the document is a series of handwritten notes or entries, similar to the previous parts. These are also written in a cursive script and are organized into paragraphs.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23115

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patsy Lou Greear</b>				2. Date of Death Month Day Year <b>July 4, 2000</b>				3. Time of Death <b>0323</b>	
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>				4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>316-36-6939</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>June 14, 1936</b>		9. Birthplace (State or Foreign Country) <b>Illinois</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>477 Eastern Ct.</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>	
	16b. Kind of Business/Industry <b>U.S. Government</b>		17. Father's Name (First, Middle, Last) <b>Clark Howerton Wilkinson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nannie Alberta Wallace</b>		19a. Informant's Name/Relationship (Type, Print) <b>Norman Lee Greear / Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>477 Eastern Ct., Aberdeen, MD 21001</b>	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wolf Creek Cemetery</b>		20c. Location - City or Town, State <b>7-7-00 Eldorado, Illinois</b>		21. Signature of Funeral Service Licenses <i>Charles A. Emge</i>		22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac ARREST</b> Due to (or as a consequence of): <b>b. Acute Myocardial infarction</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>George L. Henry MD</i>		29c. License number <b>DO 6547</b>		29d. Date signed (Month, Day, Year) <b>7/5/2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE L. HENRY MD - 601 S. Union Ave Havre de Grace MD</b>		31. Date filed (Month, Day, Year) <b>JUL 5 2000</b>		32. Registrar's Signature <i>Beverly B. Sparks</i>					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23116

Amend Line #20a, 20b, 20c hchd Certificate of Death 7/10/00 Reg. No. SH.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Robert Edward Lee Grace</b>		2. Date of Death Month <b>July</b> Day <b>3</b> Year <b>2000</b>		3. Time of Death <b>0905</b>	
4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>
5. Social Security Number <b>212-28-4625</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>March 16, 1930</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>

Funeral  
Director

Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
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10e. Street and Number <b>100 Revolution Street Apt. 512</b>		10f. Zip Code <b>21078</b>		10g. Citizen of What Country? <b>USA</b>	
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11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
--	--	---	--	--	--	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>		16b. Kind of Business/Industry <b>Restaraunt</b>	
--	--	--	--	---	--

17. Father's Name (First, Middle, Last) <b>James E. Grace</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lura DeBoard</b>	
--	--	--	--

19e. Informant's Name/Relationship (Type, Print) <b>Elizabeth A. Horn (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>110 Idlewild Road, BelAir, Maryland 21014</b>	
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>B.A. Ferris &amp; Co. Inc. Welcome Home Baptist Cent.</b>		20c. Location - City or Town, State <b>West Chester, PA. BelAir, Maryland</b>	
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21. Signature of Funeral Service Licensee <b>Kenneth B. Gargo</b>		22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>	
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Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Respiratory failure</b> Due to (or as a consequence of): <b>b. Chronic Obstructive Pulmonary disease</b> Due to (or as a consequence of): <b>c. Chronic Bronchial Asthma</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>1 day</b> <b>4 years</b>	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery disease</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
--	--	--	--

24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
---	--	--	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature] MD</b>		29c. License number <b>D 20215</b>		29d. Date signed (Month, Day, Year) <b>7/15/00</b>	
---	--	--	--	---------------------------------------	--	---	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KARMACHANDRA S. NAIR MD, 601 S. Union Ave. Havre de Grace, MD 21078</b>	
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State  
Registrar

31. Date filed (Month, Day, Year) <b>JUL 6 2000</b>		32. Registrar's Signature <b>[Signature]</b>	
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ORIGINAL

Dr. K. Nair 0905  
Baltimore, Maryland 21215-0020

7/3/00  
Grace, Robert  
Division of Vital Records, P.O. Box 68760, SH

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23117

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 00238.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Eileen Marie Herman						2. Date of Death Month Day Year July 4 2000			3. Time of Death 12:10pm		
4a. Facility Name (If not institution, give street and number) 855 Snowfall Way						4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
5. Social Security Number 151-40-7930		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr 28 1955		9. Birthplace (State or Foreign Country) NJ			
Usual Residence of Decedent											
10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 855 Snowfall Way						10f. Zip Code 21157		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) John Hamilton						18. Mother's Name (First, Middle, Maiden Surname) Marion Imhof					
19a. Informant's Name/Relationship (Type, Print) Glenn Herman/Husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 855 Snowfall Way Westminster, MD 21157					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joes Cemetery		Date 7/8		20c. Location - City or Town, State Toms River, NJ			
21. Signature of Funeral Service licensee 						22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death minutes	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number 00051924			29d. Date signed (Month, Day, Year) July 5, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Harbert P Henderson Jr. MD 295 Stoner Ave Suite 307 Westminster MD 21157											
31. Date filed (Month, Day, Year) JUL 06 2000		32. Registrar's Signature 									

State  
Registrar





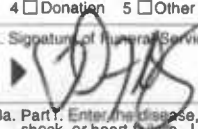
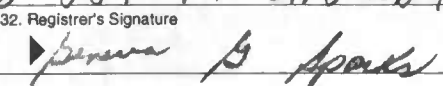
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23118

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THELMA LUCILLE HALEY</b>						2. Date of Death Month Day Year <b>JULY 6, 2000</b>		3. Time of Death <b>6:42 AM</b>										
	4a. Facility Name (If not institution, give street and number) <b>MONTGOMERY GENERAL HOSPITAL</b>						4b. City, Town, or Location of Death <b>OLNEY</b>		4c. County of Death <b>MONTGOMERY</b>										
Funeral Director	5. Social Security Number <b>216-03-6915</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 7, 1908</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>										
	Usual Residence of Decedent																		
10a. State <b>MD.</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>FULTON</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>P.O. BOX 357 7365 PINDELL SCHOOL RD.</b>				10f. Zip Code <b>20759</b>		10g. Citizen of What Country? <b>USA</b>													
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> Collage (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>			16b. Kind of Business/Industry <b>HOME MAKING</b>												
17. Father's Name (First, Middle, Last) <b>CHARLES W. PRICE</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>ALICE VIRGINIA CUTSAIL</b>													
19a. Informant's Name/Relationship (Type, Print) <b>GINGER WEIGHT -DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7365 PINDELL SCHOOL RD. P.O. BOX 357 FULTON, MD 20759</b>															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MEADOW BRANCH CEM.</b>		Date <b>7/8/00</b>		20c. Location - City or Town, State <b>WESTMINSTER, MD.</b>											
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157</b>															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>CONGESTIVE HEART FAILURE</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>24 Hours</b>   <b>YEARS</b>   <b>YEARS</b> </td> </tr> <tr> <td>b.</td> <td><b>VALVULAR HEART DISEASE</b></td> </tr> <tr> <td>c.</td> <td><b>RHEUMATIC FEVER</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>CONGESTIVE HEART FAILURE</b>	Approximate Interval Between Onset and Death  <b>24 Hours</b>  <b>YEARS</b>  <b>YEARS</b>	b.	<b>VALVULAR HEART DISEASE</b>	c.	<b>RHEUMATIC FEVER</b>	d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>CONGESTIVE HEART FAILURE</b>	Approximate Interval Between Onset and Death  <b>24 Hours</b>  <b>YEARS</b>  <b>YEARS</b>																
	b.	<b>VALVULAR HEART DISEASE</b>																	
	c.	<b>RHEUMATIC FEVER</b>																	
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>025947</b>		29d. Date signed (Month, Day, Year) <b>JULY 6, 2000</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>EVYEN JACKSON, MD 5540 TOWN OAKS RD, CHARLSTON, MD 21029</b>																			
31. Date filed (Month, Day, Year) <b>JUL 07 2000</b>				32. Registrar's Signature 															

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

00 23119

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Helen Mae Higdon

2. Date of Death

Month Day Year  
July 02 2000

3. Time of Death

6:10am

4a. Facility Name (If not Institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

219-20-2312

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
06/26/1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

655 Alliance St.

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Licensed Practical Nurse

16b. Kind of Business/Industry

Hospital/Nursing Home

17. Father's Name (First, Middle, Last)

Emory Davis

18. Mother's Name (First, Middle, Maiden Surname)

Isabell Martz

19a. Informant's Name/Relationship (Type, Print)

Denise H. Taylor- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

655 Alliance St., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Grdns.

Date

7/6/00

20c. Location - City or Town, State

Aberdeen, MD

21. Signature of Funeral Service Licensee

Laure M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace, MD 21078

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic ca of breast

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. pancytopenia due to chemotherapy  
Due to (or as a consequence of):  
c. Cardiomypopathy probably 2%  
Due to (or as a consequence of):  
d. Adrenapexi

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brian T. Yeo - MD

29c. License number

D 15152

29d. Date signed (Month, Day, Year)

7/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian T. Yeo 801 South Union Ave., Havre de Grace, MD 21078

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 3 - 2000

32. Registrar's Signature

Brian T. Yeo

ORIGINAL

Physician  
/Medical  
ExaminerHogdon Helen  
7/2/00 0610  
Division of Vital Records, P.O. Box 68760, 21202

10



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State of Maryland / Department of Health and Mental Hygiene

Amend Item#1 HCHD 7/5/00 bh Certificate of Death

Reg. No.

00 23120

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Franklin Ray Harned

2. Date of Death

Month Day Year  
June 30 2000

3. Time of Death

4:50 AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

-----

Funeral  
Director

5. Social Security Number

453-72-3286

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 31, 1943

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

245 Melrose Court

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1965

1968

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Container Manufacturing

17. Father's Name (First, Middle, Last)

Charles Franklin Harned

18. Mother's Name (First, Middle, Maiden Surname)

MaryJo (nmn) Hefnern

19e. Informant's Name/Relationship (Type, Print)

Joel R. Harned/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Alexander Chase, Apt. F, Sparks, MD 21152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest Vet. Cem. 7/3/00

Date

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

McComas Funeral Home, P.A.

50 W. Broadway Street, Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS.

Due to (or as a consequence of):

b. SMALL CELL LUNG CANCER.

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

13 DAYS.

10 Days

14 YEARS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier  
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* RESIDENT.

29c. License number

P-12598

29d. Date signed (Month, Day, Year)

JUNE 30 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SIMEON OBERG. JOHNS HOPKINS HOSPITAL, BALTIMORE, M.D.

31. Date filed (Month, Day, Year)

JUL 5 2000

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23121

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD EDWARD HOPKINS SR

2. Date of Death

Month Day Year  
JULY 8 2000

3. Time of Death

08:26 AM

4a. Facility Name (If not institution, give street and number)

ER FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

212-32-0282

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 20, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18 Mountain Road

10f. Zip Code

21047

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Service Director

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Murray Lindley Hopkins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Alice Gertrude Walbeck

19a. Informant's Name/Relationship (Type, Print)

Elizabeth G. Hopkins- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 Mountain Road, Fallston, Maryland 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Memorial Gardens

Date

7/11/00

20c. Location - City or Town, State

Fallston, Maryland

21. Signature of Funeral Service Licensee

Stephen A. Hughes

22. Name and Address of Facility

McComas Funeral Home, P.A.

50 W. Broadway Street, Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

e.

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State of Maryland / Department of Health and Mental Hygiene

00 23122

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ernest Hedrick Halteman

2. Date of Death

Month  
JulyDay  
6Year  
2000

3. Time of Death

8:40 AM

4a. Facility Name (If not institution, give street and number)

14342 National Pike

4b. City, Town, or Location of Death

Clear Spring,

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-54-3821

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 9, 1945

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Clear Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14342 National Pike

10f. Zip Code

21722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th gradeCollege (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

self/employed

17. Father's Name (First, Middle, Last)

Norman A. Halteman

18. Mother's Name (First, Middle, Maiden Surname)

Viola Hedrick

19a. Informant's Name/Relationship (Type, Print)

Alice M. Halteman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14342 National Pike Clear Spring, MD 21722

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Mennonite Fellowship Cemetery

Date

July 10, 2000  
Hagerstown, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald Edwin Thompson Funeral Home, Inc  
P.O. BOX 310 Clear Spring, MD 21722

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non-Hodgkin's Lymphoma  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

041667

29d. Date signed (Month, Day, Year)

7.6.00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael McCormack 1110 Medical Campus Rd. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

JUL 07 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23123

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Calvin Reeder Hill</b>				2. Date of Death Month <u>July</u> Day <u>10</u> Year <u>2000</u>		3. Time of Death <u>0605</u>	
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>215-14-1857</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 10, 1905</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>669 Forest Drive</b>		10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>mechanical equipment processor</b>		16b. Kind of Business/Industry <b>Letterkenny</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Calvin Hill</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Josephine Reeder</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jo Anne Jackson Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>218 Pangborn Blvd. Hagerstown, Maryland 21740</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery</b>		Date <b>7/13/00</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i>				22. Name and Address of Facility <b>Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland 21740</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Bilateral Pneumonia</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <u>10 days</u>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Acute Renal Failure</u>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Edmond Moody</i>			
	29c. License number <b>107857</b>				29d. Date signed (Month, Day, Year) <u>July 10, 2000</u>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr Moody 1190 Mt. Airna Road Hagerstown Maryland</b>							
	31. Date filed (Month, Day, Year) <b>JUL 11 2000</b>				32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 23124

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George W. Harris				2. Date of Death Month Day Year July 3, 2000		3. Time of Death 0735	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 438-18-3906	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 14, 1921		9. Birthplace (State or Foreign Country) Louisiana
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Temple Hills			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6207 Joyce Drive				10f. Zip Code 20748		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper			16b. Kind of Business/Industry Library	
17. Father's Name (First, Middle, Last) Isaac Harris				18. Mother's Name (First, Middle, Maiden Surname) Lillie Pearl Smith				
19a. Informant's Name/Relationship (Type, Print) Isaac F. Harris/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Natures Way Prince Frederick, MD 20678				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 7/4/00		20c. Location - City or Town, State Alexandria, VA	
21. Signature of Funeral Service Licensee <i>Bladys G. Swell</i>				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pulmonary Cancer</i> Due to (or as a consequence of): b. <i>Brain Tumor due to Metastasis</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Chadomew</i>						
29c. License number D052023		29d. Date signed (Month, Day, Year) 7/3/00						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Romero, M.D. Clinton, MD								
31. Date filed (Month, Day, Year) JUL 07 2000		32. Registrar's Signature <i>B. Sparks</i>						

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23125

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Amelia Johnson

2. Date of Death

Day Year  
July 8, 2000

3. Time of Death

4:30 pm

4a. Facility Name (If not institution, give street and number)

Williamsport Nursing Home

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-16-1884

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 7, 1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Clear Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12259 Boyd Road

10f. Zip Code

21722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Title Clerk

16b. Kind of Business/Industry

State Govt.

17. Father's Name (First, Middle, Last)

Francis Pete Hull

18. Mother's Name (First, Middle, Maiden Surname)

Olive Blanche Carbaugh

19a. Informant's Name/Relationship (Type, Print)

Harry V. Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12259 Boyd Rd. Clear Spring, MD 21722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Little Rose Hill Cem.

Date

July 11, 2000  
Clear Spring, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald Edwin Thompson Funeral Home, Inc  
P.O. BOX 310 Clear Spring, MD 2172223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Amyotrophic Lateral Sclerosis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D33700

29d. Date signed (Month, Day, Year)

July 9, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TED E. HOWE

7542 OVERLOOK DR.

BOONSBORO, MD 21713

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

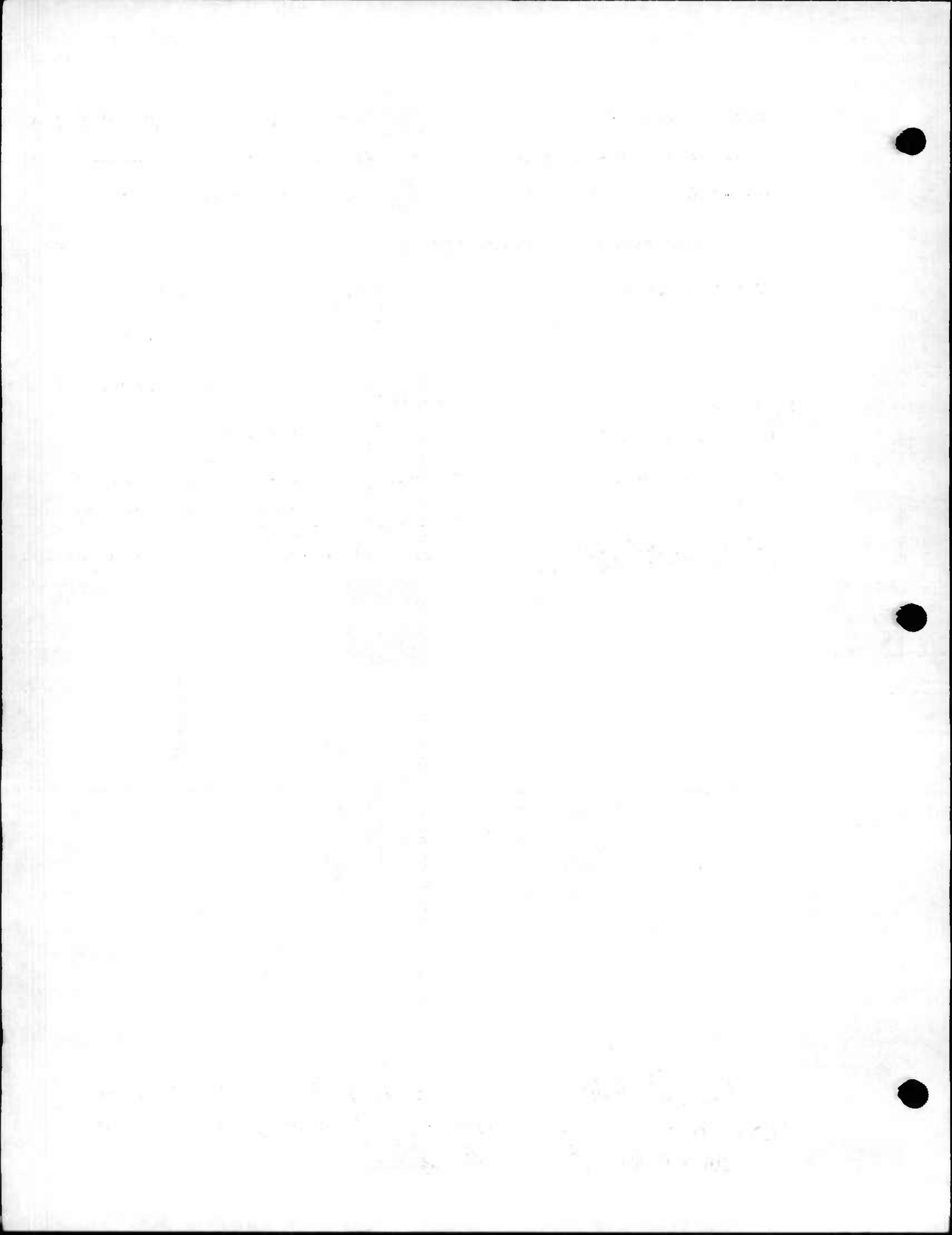
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-358-2020.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23126

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARIS ANN Johnson

2. Date of Death

Month 7 Day 20 Year 2000

3. Time of Death

0158

4a. Facility Name (If not institution, give street and number)

Dorchester Hospital

4b. City, Town, or Location of Death

Cambridge, MD

4c. County of Death

Dorchester

5. Social Security Number

214-32-260

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 20 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

412 Edlon Park

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

health care

17. Father's Name (First, Middle, Last)

Walter Beaner Andrews

18. Mother's Name (First, Middle, Maiden Summa)

Mary Robinson

19a. Informant's Name/Relationship (Type, Print)

Diane J. Hoge - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

704 Maryland Ave., Cambridge MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 7/10/00 Hurlock, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kenneth R. Johnson

22. Name and Address of Facility

Thomas Funeral Home PA

700 Locust St. Cambridge, MD 21613

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

mins

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Noel Hunte M.D.

29c. License number

00055225

29d. Date signed (Month, Day, Year)

7/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Noel Hunte, M.D. 606 Dutchman's Lane, Easton MD 21601

31. Date filed (Month, Day, Year)

JUL 11 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Handwritten signature and date: 2008 JUL 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23127

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                 |                                                                                                |                                                                                                                   |                                                             |                                                                                                                                         |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><b>Daniel Edward Johnson</b>                           |                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>June 29, 2000</b> |                                 |                                                                                                |                                                                                                                   | 3. Time of Death<br><b>8:20am</b>                           |                                                                                                                                         |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not Institution, give street and number)<br><b>St. Mary's Nursing Center</b> |                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Leonardtown</b> |                                 |                                                                                                |                                                                                                                   | 4c. County of Death<br><b>St. Mary's</b>                    |                                                                                                                                         |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br><b>579-20-2282</b>                                                    |                                                                                                                                                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.           |                                 | 8. Date of Birth (Month, Day, Year)<br><b>December 31, 1919</b>                                |                                                                                                                   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |                                                                                                                                         |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Usual Residence of Decedent                                                                        |                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Leonardtown</b>          |                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                   |                                                             |                                                                                                                                         |  |  |
| 10e. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    | 10b. County<br><b>St. Mary's</b>                                                                                                                                 |                                                                            | 10f. Zip Code<br><b>20650</b>                                                                                                                                                                                                                                                               |                                                            |                                 |                                                                                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                    |                                                             |                                                                                                                                         |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944-46</b> |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |                                                            |                                 |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                           |                                                             |                                                                                                                                         |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    |                                                                                                                                                                  |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                                                                                                                                                            |                                                            |                                 |                                                                                                | 16b. Kind of Business/Industry<br><b>Government</b>                                                               |                                                             |                                                                                                                                         |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Daniel S. Johnson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                    |                                                                                                                                                                  |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lula B. Tibbs</b>                                                                                                                                                                                                                   |                                                            |                                 |                                                                                                |                                                                                                                   |                                                             |                                                                                                                                         |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lula M. Clayton, daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                    |                                                                                                                                                                  |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22721 Wicomico Drive, Bushwood, Maryland, 20621</b>                                                                                                                                     |                                                            |                                 |                                                                                                |                                                                                                                   |                                                             |                                                                                                                                         |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    |                                                                                                                                                                  |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evergreen Memorial Gardens</b>                                                                                                                                                                                 |                                                            | Date<br><b>7/3/00</b>           |                                                                                                | 20c. Location - City or Town, State<br><b>Great Mills, Maryland</b>                                               |                                                             |                                                                                                                                         |  |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                                                                  |                                                                            | 22. Name and Address of Facility<br><b>Sterling Funeral</b><br><b>1601 Kenilworth Avenue, N.E., Washington, DC 20019</b>                                                                                                                                                                    |                                                            |                                 |                                                                                                |                                                                                                                   |                                                             |                                                                                                                                         |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>End Stage Renal Disease</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Hypertension</b><br><b>Type II Diabetes</b><br><br><br>Approximate Interval Between Onset and Death<br><b>Ten years.</b><br><b>Two years.</b> |                                                                                                    |                                                                                                                                                                  |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                            |                                 |                                                                                                |                                                                                                                   |                                                             |                                                                                                                                         |  |  |
| 24. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |                                                                                                                                                                  |                                                                            | 25. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            |                                 |                                                                                                | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No             |                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    |                                                                                                                                                                  |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                            | 28b. Time of Injury<br><b>M</b> |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                  |                                                             | 28d. Describe how injury occurred                                                                                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                       |                                                                                                    |                                                                                                                                                                  |                                                                            | 29b. Signature and title of certifier<br><b>SC6abz M.D.</b>                                                                                                                                                                                                                                 |                                                            |                                 |                                                                                                | 29c. License number<br><b>D54346</b>                                                                              |                                                             | 29d. Date signed (Month, Day, Year)<br><b>7/1/00</b>                                                                                    |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Chandra Sajja, 24035 Three Notch Road, Hollywood, Maryland 20636</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                                                                  |                                                                            | 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                     |                                                            |                                 |                                                                                                | 32. Registrar's Signature<br> |                                                             |                                                                                                                                         |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

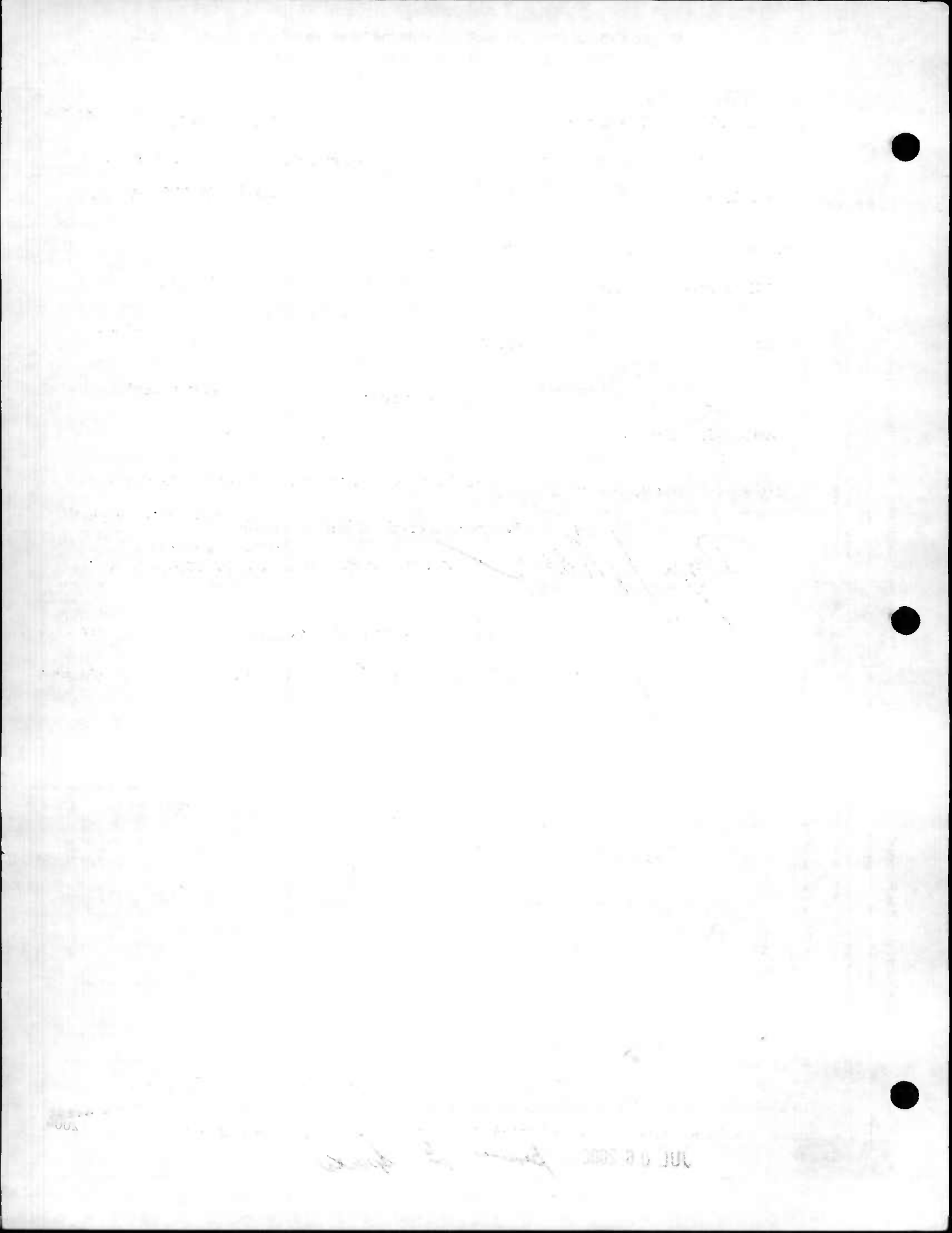
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



jhm  
LOUISE  
JACKS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23128

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Louise Jacks</b>                                      |                                                                                                                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br><b>JUNE 29, 2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>21:45 PM</b>        |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>1234 MT. ZION-MARLBORO ROAD</b> |                                                                                                                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br><b>LOTHIAN</b>     |                                                                                                                                                                                              | 4c. County of Death<br><b>ANNE ARUNDEL</b> |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>214-58-1009</b>                                                      | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.           | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>May 17, 1943</b>                                           |                                                                                                                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>Alabama</b> |                                                                                                                                                                                              |                                            |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                                       |                                                            | 10c. City, Town or Location<br><b>Lothian</b>                                                                                                                                                |                                            |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 10e. Street and Number<br><b>1234 Marlboro Road</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      | 10f. Zip Code<br><b>20711</b>                                                                                                                                                                                                                                                                            |                                                            | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |                                            |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                        |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                            |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)                                                                                                                                                                                                                                                                                               |                                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                                                                                                                            |                                                            | 16b. Kind of Business/Industry<br><b>Own Home</b>                                                                                                                                            |                                            |
| 17. Father's Name (First, Middle, Last)<br><b>Clarence Royal</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosamae Baker</b>                                                                                                                                                                                                                                |                                                            |                                                                                                                                                                                              |                                            |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Florence Jacks-Stoddard/Daughter</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8706 Dangerfield Place Clinton, MD 20735</b>                                                                                                                                                         |                                                            |                                                                                                                                                                                              |                                            |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Hope UMC Cemetery</b>                                                                                                                                                                                                   |                                                            | 20c. Location - City or Town, State<br><b>7/7/00 Sunderland, MD</b>                                                                                                                          |                                            |
| 21. Signature of Funeral Service Licensee<br><b>Blacks G. Sewell</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      | 22. Name and Address of Facility<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD 20678</b>                                                                                                                                                                                       |                                                            |                                                                                                                                                                                              |                                            |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Cirrhosis of Liver</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Right Ovarian and Omental Infarct / Torsion</b><br>Due to (or as a consequence of):                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Lymphoma in Remission</b><br><b>Right Ovarian and Omental Infarct / Torsion</b>                                                                                                                                                                                                              |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                               |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                            |                                                                                                                                                                                              |                                            |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                   |                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                            |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                      | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                        |                                                            | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)                                                                                                       |                                            |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 29b. Signature and title of certifier<br><b>Dennis J. Chute</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | 29c. License number<br><b>OCME</b>                                                                                                                                                                                                                                                                       |                                                            | 29d. Date signed (Month, Day, Year)<br><b>JUNE. 30, 2000</b>                                                                                                                                 |                                            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                            |
| 31. Date filed (Month, Day, Year)<br><b>JUL 07 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                                            |                                                            |                                                                                                                                                                                              |                                            |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

00 23129

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |                                                          |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>James Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>July 8, 2000                                                                                                                                                |  | 3. Time of Death<br>6:05 A.M.                                                                                                                                                                            |                                                          |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>3285 Hance Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Port Republic                                                                                                                                             |  | 4c. County of Death<br>Calvert                                                                                                                                                                           |                                                          |
| Funeral<br>Director                           | 5. Social Security Number<br>217-32-2599                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                              |  | 7. Age (In yrs. last birthday)<br>63 Yrs.                                                                                                                                                         |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 8, 1936                                                                                                                                                      |                                                          |
|                                               | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                  |  | 10b. County<br>Calvert                                                                                                                                                                            |  | 10c. City, Town or Location<br>Port Republic                                                                                                                                                             |                                                          |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10e. Street and Number<br>3285 Hance Road                                                                                                                                                                                                                                                               |  | 10f. Zip Code<br>20676                                                                                                                                                                            |  | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |                                                          |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                                                                                                                         |                                                          |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                                                                                                                                                                                    |  | 16b. Kind of Business/Industry<br>State Highway Adminis.                                                                                                                                          |  |                                                                                                                                                                                                          |                                                          |
|                                               | 17. Father's Name (First, Middle, Last)<br>John Albert Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ernestine Gray                                                                                                                               |  |                                                                                                                                                                                                          |                                                          |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Amelia Johnson/Wife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3285 Hance Road Port Republic, MD 20676                                                          |  |                                                                                                                                                                                                          |                                                          |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Brooks UM Church Cemetery                                                                                                                                                                                                     |  | 20c. Location - City or Town, State<br>St. Leonard, MD                                                                                                                                            |  | 20d. Date<br>7/12/00                                                                                                                                                                                     |                                                          |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Bladys A. Sewell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Sewell Funeral Home<br>1451 Dares Beach Rd. Prince Frederick, MD 20678                                                                                        |  |                                                                                                                                                                                                          |                                                          |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>LUNG CANCER<br>Due to (or as a consequence of):<br>RENAL FAILURE<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of): |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          | Approximate Interval Between Onset and Death<br>6 months |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                          |
|                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                          |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |                                                          |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                 |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |  | 28b. Time of Injury<br>M                                                                                                                                                                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                          |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |  |                                                                                                                                                                                                          |                                                          |
|                                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |                                                          |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>Charles A. Judge, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 29c. License number<br>029657                                                                                                                                                                     |  | 29d. Date signed (Month, Day, Year)<br>7/10/2000                                                                                                                                                         |                                                          |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Charles A. Judge, M.D. Prince Frederick, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |                                                          |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 32. Registrar's Signature<br>Benita B. Sparks                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |                                                          |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23130

|                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br>Rose A. Koch                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br>July 3 2000                                                                                                                                                                                                                                                       |                                                                  | 3. Time of Death<br>4:00 PM                                                                        |  |
|                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br>35 Strawhat 1B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br>Owings Mills                                                                                                                                                                                                                                                    |                                                                  | 4c. County of Death<br>Baltimore                                                                   |  |
| Funeral<br>Director                                                                                                                               | 5. Social Security Number<br>216-48-1005                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                     | 7. Age (In yrs. last birthday)<br>53 Yrs.                                                                                                                                                         |  | 8. Date of Birth (Month, Day, Year)<br>Feb 2, 1947                                                                                                                                                                                                                                                      |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                               |  |
|                                                                                                                                                   | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                               | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. County<br>Baltimore                                                                                                                              |                                                     | 10c. City, Town or Location<br>Owings Mills                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                   | 10e. Street and Number<br>35 Strawhat 1B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                                     | 10f. Zip Code<br>21117                                                                                                                                                                            |  | 10g. Citizen of What Country?<br>United States                                                                                                                                                                                                                                                          |                                                                  |                                                                                                    |  |
|                                                                                                                                                   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                                                                                                                                                                                                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                                                                                                                   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>9th                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |                                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Manager                                                                              |  |                                                                                                                                                                                                                                                                                                         | 16b. Kind of Business/Industry<br>Dunkin Donuts                  |                                                                                                    |  |
|                                                                                                                                                   | 17. Father's Name (First, Middle, Last)<br>William Lester Smith                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Allyne E. Smith                                                                                                                                                                                                                                    |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Virginia Gregory (Sister)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>35 Strawhat 1B Owings Mills, Md 21117                                                            |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
|                                                                                                                                                   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Emory Cemetery                                                              |                                                     | 20c. Date<br>7/7/00                                                                                                                                                                               |  | 20d. Location - City or Town, State<br>Upperco, MD                                                                                                                                                                                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                   | 21. Signature of Funeral Service Licensee<br><i>James B. Cuy</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                     | 22. Name and Address of Facility<br>Burrier-Queen Funeral Directors, PA<br>1212 West Old Liberty Rd. Winfield, MD 21784                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
|                                                                                                                                                   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>LUNG CANCER</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
|                                                                                                                                                   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
| State<br>Registrar                                                                                                                                | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                  |                                                                                                    |  |
|                                                                                                                                                   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                          |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |                                                     | 28b. Time of Injury<br>M                                                                                                                                                                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                    |                                                                  | 28d. Describe how injury occurred                                                                  |  |
|                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                          |                                                     |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
|                                                                                                                                                   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                  |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
|                                                                                                                                                   | 29b. Signature and title of certifier<br><i>Flavio Kruter MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                     | 29c. License number<br>D35398                                                                                                                                                                     |  | 29d. Date signed (Month, Day, Year)<br>7-5-00                                                                                                                                                                                                                                                           |                                                                  |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Flavio Kruter 224 Washington Heights Westminster MD 21157 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |                                                     |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 2000                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       | 32. Registrar's Signature<br><i>James B. Sparks</i> |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                    |  |



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amend item 28a-f per me G785 7/21/00 State of Maryland / Department of Health and Mental Hygiene

AMEND: #18 mcg 5/23/00 AACO Health Certificate of Death

Reg. No. 00 23131

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Marlene Elizabeth Kvichak</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 2. Date of Death<br>Month Day Year<br><b>May 19 2000</b>                                        |                                                                         | 3. Time of Death<br><b>3:00pm</b>                                                                                                                                                                        |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1213 Viking Drive North</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 4b. City, Town, or Location of Death<br><b>Arnold</b>                                           |                                                                         | 4c. County of Death<br><b>Anne Arundel</b>                                                                                                                                                               |  |
| 5. Social Security Number<br><b>173-42-3845</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (in yrs. last birthday)<br><b>49</b> Yrs.                                                                                                                                                 |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 9, 1951</b>                                       |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                          |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                                      |  | 10c. City, Town or Location<br><b>Arnold</b>                                                                                                                                                     |  |                                                                                                 |                                                                         | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |  |
| 10e. Street and Number<br><b>1213 Viking Drive North</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br><b>21012</b>                                                                                                                                                                    |  | 10g. Citizen of What Country?<br><b>USA</b>                                                     |                                                                         |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>                                                                        |  |                                                                                                 | 16b. Kind of Business/Industry<br><b>Home Health Care</b>               |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Graban</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jean Okjlewica - Okjlewicz</b>          |                                                                         |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas Kvichak/ husband</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1213 Viking Drive North, Arnold, MD 21012</b>                                                |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                                                                                                                                                                        |  | Date<br><b>May 23 2000</b>                                                                                                                                                                       |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                     |                                                                         |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br><b>► Rounts B...</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>                                                 |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. carbon monoxide poisoning</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>two hours</b> |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                 |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                 |                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                  |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                            |  | 28a. Date of Injury (Month, Day, Year)<br><b>May 19, 2000</b>                                                                                                                                                                                                                                           |  | 28b. Time of Injury<br><b>unknown</b> M                                                                                                                                                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred<br><b>inhaled exhaust fumes from auto</b>                                                                                                                              |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>home garage</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1213 Viking Dr. North Arnold, Md.</b>                                                                         |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                     |  | 29b. Signature and title of certifier<br><b>► Jeffrey Briggs M.D.</b>                                                                                                                                                                                                                                   |  | 29c. License number<br><b>D28640</b>                                                                                                                                                             |  | 29d. Date signed (Month, Day, Year)<br><b>May 19, 2000</b>                                      |                                                                         |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>2414 Hightee Ct. Crofton Md 21114</b><br><b>Jeffrey Briggs, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 23 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. Registrar's Signature<br><b>► [Signature]</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                  |  |                                                                                                 |                                                                         |                                                                                                                                                                                                          |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23132

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Franklin Knisley, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 2. Date of Death<br>Month <b>07</b> Day <b>09</b> Year <b>2000</b>               |                                                                         | 3. Time of Death<br><b>4:45 PM</b>                                                             |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Dorchester General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 4b. City, Town, or Location of Death<br><b>Cambridge</b>                         |                                                                         | 4c. County of Death<br><b>Dorchester</b>                                                       |  |
| 5. Social Security Number<br><b>214-28-9400</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.                                                                                                                                                |  | 8. Date of Birth (Month, Day, Year)<br><b>June 2, 1933</b>                       |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. County<br><b>Dorchester</b>                                                                                                                                                                                                                                                            |  | 10c. City, Town or Location<br><b>Taylor's Island</b>                                                                                                                                           |  |                                                                                  |                                                                         | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>4402 Hoopertown Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>21669</b>                                                                                                                                                                   |  | 10g. Citizen of What Country?<br><b>US</b>                                       |                                                                         |                                                                                                |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                                                                   |  |                                                                                  | 16b. Kind of Business/Industry<br><b>Construction</b>                   |                                                                                                |  |
| 17. Father's Name (First, Middle, Last)<br><b>Julian Oliver Knisley, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sadie Lee Whetzel</b>    |                                                                         |                                                                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria W. Knisley Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 71 Taylor's Island, Maryland 21669</b>                                             |  |                                                                                  |                                                                         |                                                                                                |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>                                                                                                                                                                                        |  | Data<br><b>7/11/00</b>                                                                                                                                                                          |  | 20c. Location - City or Town, State<br><b>Salisbury, Maryland</b>                |                                                                         |                                                                                                |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>Thomas Funeral Home, P.A.<br/>700 Locust Street Cambridge, Maryland 21613</b>                                                                            |  |                                                                                  |                                                                         |                                                                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Interstitial Pulmonary Fibrosis</b> 9 months<br>Due to (or as a consequence of):<br>b. <b>Rheumatoid Lung Disease</b> 1 year<br>Due to (or as a consequence of):<br>c. <b>Rheumatoid Arthritis</b> years<br>Due to (or as a consequence of):<br>d. <b>mild congestive heart failure</b> 5 days<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease</b><br><b>Atrial fibrillation</b><br><b>Hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                         |  |                                                                                  |                                                                         |                                                                                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br>M                                                                                                                                                                        |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                              |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
| 29b. Signature and title of certifier<br><b>MCJ Rajasingh M.D. FACC</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>D 41723</b>                                                                                                                                                           |  | 29d. Date signed (Month, Day, Year)<br><b>7/10/2000</b>                          |                                                                         |                                                                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M.C. Rajasingh, MD 403 Marvel Court Easton, Maryland 21601</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                         |                                                                                                |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Handwritten signatures and the date "JUL 1 1960" are visible at the bottom of the page.



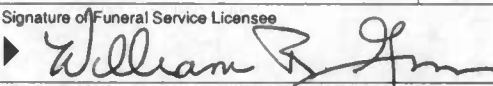

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State of Maryland / Department of Health and Mental Hygiene

00 23133

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Estill Jay KING</b>                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            | 2. Date of Death<br>Month Day Year<br><b>July 4 2000</b>                                                                                                                                         |                                                                                                    | 3. Time of Death<br><b>9:15 p.m.</b>                                    |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert County Nursing Center</b>                                                                                                                                          |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>                                                                                                                                  |                                                                                                    | 4c. County of Death<br><b>Calvert</b>                                   |                                                                                                                                                                                                          |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>403 10 9562</b>                                                                                                                                                                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                            | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.                                                                                                      | If Under 1 Year<br>Months Days                                                                                             | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 24, 1916</b>                                        |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Kentucky</b>                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                   | 10b. County<br><b>Calvert</b>                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br><b>Owings</b>                                                                                                          |                                                                                                                            |                                                                                                                                                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. Street and Number<br><b>9201 Easy Street</b>                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       | 10f. Zip Code<br><b>20736</b>                                                                                              |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br><b>USA</b>                                                        |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                          |                                                                                                                                                                                                                                                                                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)                                                                                                                 |                                                                                                                                                                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>coal miner</b>                        |                                                                                                                            | 16b. Kind of Business/Industry<br><b>coal mining</b>                                                                                                                                             |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 17. Father's Name (First, Middle, Last)<br><b>James King</b>                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Castle</b>                                                  |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>James F. King, Sr., son</b>                                                                                                                                                              |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as # 10 above</b> |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>                                                 |                                                                                                                            | Date<br><b>7-7-00</b>                                                                                                                                                                            |                                                                                                    | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>             |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                 |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A., Owings, MD 20736</b>                                     |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Myocardial Infarction</b>       |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         | Approximate Interval Between Onset and Death<br><b>unknown</b>                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | a. Due to (or as a consequence of):                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | b. Due to (or as a consequence of):                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | c. Due to (or as a consequence of):                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                 |                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                 |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                            |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                                         | 28d. Describe how Injury occurred                                                                                                                                                                        |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                 | 29b. Signature and title of certifier<br> MD                                                                                                                                                                       |                                                                                                                                                       | 29c. License number<br><b>D51949</b>                                                                                       |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br><b>7/5/00</b>                                               |                                                                         |                                                                                                                                                                                                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David Gallatin 110 Hospital Rd, Suite 310 Prince Frederick MD</b>                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |
| 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br>                                                                                                                                                                                     |                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                                                  |                                                                                                    |                                                                         |                                                                                                                                                                                                          |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23134

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br><b>Renee Michelle Lovett</b>                   |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 | 2. Date of Death<br>Month Day Year<br><b>July 5, 2000</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>1:27 am</b>                          |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not Institution, give street and number)<br><b>2663 Jeanne Drive</b> |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 | 4b. City, Town, or Location of Death<br><b>Manchester</b> |                                                                                                                                                                                                  | 4c. County of Death<br><b>Carroll</b>                       |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br><b>215-84-0273</b>                                            |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.                                                                                                                                              |                                                                                                                                                 | 8. Date of Birth (Month, Day, Year)<br><b>Feb 2, 1962</b> |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                                |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                            | 10b. County<br><b>Carroll</b> |                                                                                                                                                   | 10c. City, Town or Location<br><b>Manchester</b>                                                                                                                                                                                                                                            |                                                                                                                                                                                               |                                                                                                                                                 |                                                           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                             |                                              |  |
| 10e. Street and Number<br><b>2663 Jeanne Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                            |                               |                                                                                                                                                   | 10f. Zip Code<br><b>21102</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                     |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                 |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |                                                             |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                               |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                                                                                                                                                               |                                                                                                                                                                                               |                                                                                                                                                 | 16b. Kind of Business/Industry<br><b>Own Home</b>         |                                                                                                                                                                                                  |                                                             |                                              |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Lovett, III</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Arrington</b>                                                                      |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Kreseski, companion</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2663 Jeanne Drive, Manchester, MD 21102</b> |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                               |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Lutheran Cemetery</b>                                                                                                                                                                                      |                                                                                                                                                                                               | Data<br><b>7/8</b>                                                                                                                              |                                                           | 20c. Location - City or Town, State<br><b>Manchester, MD</b>                                                                                                                                     |                                                             |                                              |  |
| 21. Signature of Funeral Service Licensee<br><b>Sharon W. Elmer</b> M00723.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                               |                                                                                                                                                   | 22. Name and Address of Facility<br><b>Eline Funeral Home</b><br><b>934 South Main St, Hampstead, MD 21074</b>                                                                                                                                                                              |                                                                                                                                                                                               |                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>INDOMETHACIN CARCINOMA.</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                            |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                             | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypercalcemia.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 |                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 |                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                             |                                              |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            |                               |                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                               |                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                               |                                                                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                                                               | 28b. Time of Injury<br><b>M</b>                                                                                                                 |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                               |                                                                                                                                                   | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                 |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                             |                                              |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                      |                                                                                            |                               |                                                                                                                                                   | 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                 |                                                           | 29c. License number<br><b>D18320</b>                                                                                                                                                             |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                               |                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br><b>July 07, 2000</b>                                                                                                                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John Fitting, MD, Johns Hopkins Oncology Ctr Baltimore MD 21287</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |                               |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                               |                                                                                                                                                   | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                             |                                              |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 23135

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                  |                                                                                           |                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                          |                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                 |                                                                                                                                                                                                                                       |                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><i>Odell May Leister</i>                      |                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                          | 2. Date of Death<br>Month <i>July</i> Day <i>4</i> Year <i>2000</i> |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                 |                                                                                                                                                                                                                                       | 3. Time of Death<br><i>12:43 PM</i>             |  |
|                                                                                                                                                                                                                                                                                                  | 4e. Facility Name (If not institution, give street and number)<br><i>Gilchrist Center</i> |                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                          | 4b. City, Town, or Location of Death<br><i>Towson</i>               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                 |                                                                                                                                                                                                                                       | 4c. County of Death<br><i>Baltimore</i>         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><i>216-12-7975</i>                                           |                                                                                                                                                                                                                                                                         | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                          | 7. Age (In yrs. last birthday)<br><i>78</i> Yrs.                    |                                                                                                                                                                                                                                                                                                                                                                                                                           | If Under 1 Year<br>Months Days  |                                                                                                                                                                                                                                       | If Under 24 Hrs.<br>Hours Min.                  |  |
|                                                                                                                                                                                                                                                                                                  | 8. Date of Birth<br>(Month, Day, Year)<br><i>Nov. 14, 1921</i>                            |                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>                |                                                                                                                                          | 10a. State<br><i>Maryland</i>                                       |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><i>Baltimore</i> |                                                                                                                                                                                                                                       | 10c. City, Town or Location<br><i>Baltimore</i> |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                      |                                                                                           | 10a. State                                                                                                                                                                                                                                                              |                                                                            | 10b. County                                                                                                                              |                                                                     | 10c. City, Town or Location                                                                                                                                                                                                                                                                                                                                                                                               |                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                        |                                                 |  |
| 10e. Street and Number<br><i>4229 Necker Ave.</i>                                                                                                                                                                                                                                                |                                                                                           | 10f. Zip Code<br><i>21236</i>                                                                                                                                                                                                                                           |                                                                            | 10g. Citizen of What Country?<br><i>U.S.A.</i>                                                                                           |                                                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                 | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                     |                                                 |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                     |                                                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                                                                                                                                                                                                 |                                                                            | 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>12th Grade</i>                                                  |                                                                     | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Group 4 Clerk</i>                                                                                                                                                                                                                                                                                      |                                 | 16b. Kind of Business/Industry<br><i>Telephone Company</i>                                                                                                                                                                            |                                                 |  |
| 17. Father's Name (First, Middle, Last)<br><i>Warren C. Miller</i>                                                                                                                                                                                                                               |                                                                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Sadie M. Workerger</i>                                                                                                                                                                                          |                                                                            | 19a. Informant's Name/Relationship (Type, Print)<br><i>Donald Leister (son)</i>                                                          |                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4229 Necker Ave., Baltimore, MD 21236</i>                                                                                                                                                                                                                                                                             |                                 | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                                 |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Dulaney Valley Mem'l Gard</i>                                                                                                                                                                                       |                                                                                           | 20c. Location - City or Town, State<br><i>Timonium, Maryland</i>                                                                                                                                                                                                        |                                                                            | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                          |                                                                     | 22. Name and Address of Facility<br><i>Schimunek Funeral Home, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</i>                                                                                                                                                                                                                                                                                                          |                                 | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |                                                 |  |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                  |                                                                                           | a. <i>Brain metastases</i>                                                                                                                                                                                                                                              |                                                                            | Due to (or as a consequence of):                                                                                                         |                                                                     | Approximate Interval Between Onset and Death<br><i>2 yrs</i>                                                                                                                                                                                                                                                                                                                                                              |                                 | b. <i>breast cancer</i>                                                                                                                                                                                                               |                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last                                                                                                                                       |                                                                                           | c.                                                                                                                                                                                                                                                                      |                                                                            | Due to (or as a consequence of):                                                                                                         |                                                                     | 3 yrs                                                                                                                                                                                                                                                                                                                                                                                                                     |                                 | d.                                                                                                                                                                                                                                    |                                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                           |                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                        |                                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                    |                                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                 | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                     |                                                 |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other <i>suicide</i> |                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                    |                                                                     | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                                                                                                                                  |                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                           |                                                 |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                |                                                                                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                  |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                             |                                                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                 | 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                           |                                                 |  |
| 29c. License number<br><i>139099</i>                                                                                                                                                                                                                                                             |                                                                                           | 29d. Date signed (Month, Day, Year)<br><i>7/4/00</i>                                                                                                                                                                                                                    |                                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Rodney Williams MD, GBMC, BALTIMORE 21204</i> |                                                                     | 31. Date filed (Month, Day, Year)<br><i>JUL 7 2000</i>                                                                                                                                                                                                                                                                                                                                                                    |                                 | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                       |                                                 |  |

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State of Maryland / Department of Health and Mental Hygiene

00 23136

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Catherine Eileen LUSHBAUGH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 | 2. Date of Death<br>Month Day Year<br>July 03 2000                |                                                                  | 3. Time of Death<br>1710                                                                                                                                                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 | 4b. City, Town, or Location of Death<br>Hagerstown                |                                                                  | 4c. County of Death<br>Washington                                                                                                                                                                        |  |                                                       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>213-18-9728                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                      | 7. Age (In yrs. last birthday)<br>77 Yrs.                                                                                                                                                        |                                                                                                 | 8. Date of Birth (Month, Day, Year)<br>Nov. 12, 1922              |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                     |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 10b. County<br>Washington                                                                                                                             |                                                                                                                      | 10c. City, Town or Location<br>Hagerstown                                                                                                                                                        |                                                                                                 |                                                                   |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br>11400 Stonecroft Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      | 10f. Zip Code<br>21742                                                                                                                                                                           |                                                                                                 | 10g. Citizen of What Country?<br>USA                              |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                 |                                                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: white |                                                                                                                                                                                                          |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>laborer |                                                                                                                                                                                                  |                                                                                                 | 16b. Kind of Business/Industry<br>dress mfg.                      |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br>Leroy Ridenour                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dessie Smith |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Sandra Nalley - daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16611 Shaffer Rd., Sharpsburg, Md. 21782                                                        |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery                                                          |                                                                                                                      | Date<br>7-6-00                                                                                                                                                                                   |                                                                                                 | 20c. Location - City or Town, State<br>Hagerstown, Maryland       |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br><i>Scott M. Minnich</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740                                                                                           |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Acute Leukemia</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  | Approximate Interval Between Onset and Death<br>weeks |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension, Diabetes Mellitus,</u><br><u>Urinary Tract Infection, Peptic Ulcer Disease,</u><br><u>Arthritis</u>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 |                                                                   |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                                       |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                       | 28b. Time of Injury<br>M                                                                                             |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                   | 28d. Describe how injury occurred                                |                                                                                                                                                                                                          |  |                                                       |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 29b. Signature and title of certifier<br><i>Cynthia Kuttner-Sands, MD</i>                                                                                                                                                                                                                               |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  | 29c. License number<br>D47451                                                                   |                                                                   | 29d. Date signed (Month, Day, Year)<br>July 4, 2000              |                                                                                                                                                                                                          |  |                                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Cynthia Kuttner-Sands, MD 11110 Medical Campus Road, Hagerstown, Maryland 21742                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |
| 31. Date filed (Month, Day, Year)<br>JUL 06 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 32. Registrar's Signature<br><i>B. Sparks</i>                                                                                                                                                                                                                                                           |                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                  |                                                                                                 |                                                                   |                                                                  |                                                                                                                                                                                                          |  |                                                       |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner



NAME: LUSHBAUGH,CATHERINE EILEEN  
11/12/1922 77 / F

DOS: 06/19/2000  
KUTTNER-SANDS,CYNTHIA



H3041778253



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State of Maryland / Department of Health and Mental Hygiene

00 23137

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUSSELL MORRISON LAPOLE

2. Date of Death

Month Day Year  
July 8, 2000

3. Time of Death

2:30 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Avalon Manor Health Care Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-05-2566

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 3, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

37 South Prospect Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Packer

16b. Kind of Business/Industry

Moving and Storage Company

17. Father's Name (First, Middle, Last)

Winton Eric Lapole

18. Mother's Name (First, Middle, Maiden Summa)

Annie Victoria Monninger

19a. Informant's Name/Relationship (Type, Print)

Shirley Y. Smith - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5562 Brittany Court, Frederick, Md. 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

07-11-2000

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

R. Noel Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.

40 East Antietam Street, Hagerstown, Md. 21740

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive Heart Failure

Due to (or as a consequence of):

b.

Anterior wall Myocardial Infarction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

few days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension malnutrition anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ ODA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Vasant Datta

29c. License number

D 18019

29d. Date signed (Month, Day, Year)

July 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vasant Datta 334 Mill Street, Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 23138

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>Jennifer Lynn Leech</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>July 04 2000</b>                                                                                                                                        |                                                                                                 |                                                            |                                                                                          | 3. Time of Death<br><b>4:00 P.M.</b>                                                               |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Cheverly</b>                                                                                                                                          |                                                                                                 |                                                            |                                                                                          | 4c. County of Death<br><b>Prince George's</b>                                                      |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>215-21-8464</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>18</b> Yrs.                                                                                                                                                 |                                                                                                 | 8. Date of Birth (Month, Day, Year)<br><b>May 10, 1982</b> |                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                        |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             | 10b. County<br><b>Calvert</b>                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br><b>Dunkirk</b>                                                                                                                                                    |                                                                                                 |                                                            |                                                                                          | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br><b>2070 McCracken Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br><b>20754</b>                                                                                                                                                                    |                                                                                                 | 10g. Citizen of What Country?<br><b>U.S.A.</b>             |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                 |                                                            |                                                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                                                                      |                                                                                                 |                                                            |                                                                                          | 16b. Kind of Business/Industry<br><b>School</b>                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br><b>Ricky Wayne Leech</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Deanna Neill</b>                                                                                                                         |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Deanna Leech (mother)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2070 McCracken Drive Dunkirk, MD 20754</b>                                                   |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Southern Mem. Grdns.</b>                                                 |                                                                                                                                                                                                                                                                                                         | Data<br><b>July 8 2000</b>                                                                                                                                                                       |                                                                                                 | 20c. Location - City or Town, State<br><b>Dunkirk, MD</b>  |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br><b>Gary J. Goff M00246</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 22. Name and Address of Facility<br><b>Lee Funeral Home Calvert, P.A.<br/>8125 Southern MD Blvd. Owings, MD 20736</b>                                                                            |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             | Approximate Interval Between Onset and Death                                                                                                                                                             |                                        |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                        |  |                                                             |  |
| 24a. Was an autopsy performed?<br><b>Approval</b><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          |                                        |  |                                                             |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day, Year)<br><b>06-17-2000</b> |                                                                                                                                                       | 28b. Time of Injury<br><b>1:39 A M</b>                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                            | 28d. Describe how injury occurred<br><b>Subject driver of a car which struck a tree.</b> |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Road</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>West Friendship Rd. near Kim Lane, Friendship, MD</b>                                                                                                                                                                |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    | 29b. Signature and title of certifier<br><b>Theodore M. King M.D.</b>                                                                       |                                                                                                                                                                                                          | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>July 07, 2000</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br><b>B. Sparks</b>               |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                 |                                                            |                                                                                          |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                        |  |                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Wash. Co. Wash. 1075-1-1 JUL

State of Maryland / Department of Health and Mental Hygiene

00 23139

amend item 10b per fh G785 7/27/00 yg

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                     |                                      |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Ferne Leora Merryman                         |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 2. Date of Death<br>Month Day Year<br>July 3, 2000                                                                                                                                                  |                                      | 3. Time of Death<br>10:00 pm                                                                    |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Long View Nursing Home |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 4b. City, Town, or Location of Death<br>Manchester                                                                                                                                                  |                                      | 4c. County of Death<br>Carroll                                                                  |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>220-03-5439                                                 |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |                                                                                                                        | 7. Age (In yrs. last birthday)<br>80 Yrs.                                                                                                                                                           |                                      | 8. Date of Birth (Month, Day, Year)<br>Jan 14, 1920                                             |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                              |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                     |                                      |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          | 10b. County<br>Baltimore              |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br>Hampstead                                                                               |                                                                                                                                                                                                     |                                      |                                                                                                 | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                          |                                                                                                                                                                                                          |  |
| 10e. Street and Number<br>4707 Mt. Carmel Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br>21074                                                                                                 |                                                                                                                                                                                                     | 10g. Citizen of What Country?<br>USA |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                      |                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                          |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife |                                                                                                                                                                                                     |                                      | 16b. Kind of Business/Industry<br>Own Home                                                      |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Soloman Rodamer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertha Hemminger                                                                                                                               |                                      |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Thomas Merryman, husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4707 Mt. Carmel Rd, Hampstead, MD 21074                                                            |                                      |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hampstead Cemetery                                                                                                                                                                                                            |                                                                                                                        | Date<br>7/7<br>4/7                                                                                                                                                                                  |                                      | 20c. Location - City or Town, State<br>Hampstead, MD                                            |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>M00723                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 22. Name and Address of Facility<br>Eline Funeral Home<br>934 South Main St, Hampstead, MD 21074                                                                                                    |                                      |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Metastatic Liver Cancer</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                     |                                      |                                                                                                 |                                                                                                    |                                                          | Approximate Interval Between Onset and Death<br>months                                                                                                                                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                     |                                      |                                                                                                 |                                                                                                    |                                                          | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                     |                                      |                                                                                                 |                                                                                                    |                                                          | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                                                                        |                                                                                                                                                                                                     |                                      |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                     |                                                                                          |                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                        | 28b. Time of Injury<br>M                                                                                                                                                                            |                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                    | 28d. Describe how injury occurred                        |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                              |                                                                                          |                                       | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                   |                                                                                                                        | 29c. License number<br>D33165                                                                                                                                                                       |                                      | 29d. Date signed (Month, Day, Year)<br>7/5/00                                                   |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Steven Shaffer 2111 Hanover Pk Hampstead MD 21074                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                          |                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                     |                                      |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 07 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          | 32. Registrar's Signature<br>B Sparks |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                     |                                      |                                                                                                 |                                                                                                    |                                                          |                                                                                                                                                                                                          |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23140

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, DC

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

State Registrar

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Laura Elizabeth Markline</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. Date of Death<br>Month <b>July</b> Day <b>03</b> Year <b>2000</b>                                                                                                                                                                                                                                     |  | 3. Time of Death<br><b>11:00 A.M.</b>                                                                                                                                                        |                                                                                                                                                                                                  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1528 Old Tower Road</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4b. City, Town, or Location of Death<br><b>Aberdeen</b>                                                                                                                                                                                                                                                  |  | 4c. County of Death<br><b>Harford</b>                                                                                                                                                        |                                                                                                                                                                                                  |
| 5. Social Security Number<br><b>215-24-6793</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                               |  | 7. Age (In yrs. last birthday)<br><b>100</b> Yrs.                                                                                                                                            |                                                                                                                                                                                                  |
| 8. Date of Birth (Month, Day, Year)<br><b>May 13, 1900</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. County<br><b>Harford</b>                                                                                                                                                                                                                                                                            |  | 10c. City, Town or Location<br><b>Aberdeen</b>                                                                                                                                               |                                                                                                                                                                                                  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>737 Mahan Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10f. Zip Code<br><b>21001</b>                                                                                                                                                                                                                                                                            |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                        |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                                                                                                                            |  | 16b. Kind of Business/Industry<br><b>In Home</b>                                                                                                                                             |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>John Runan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rachel E. Bailey</b>                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John Edward Markline (son)</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>735 Mahan Road, Aberdeen, Maryland 21001</b>                                                                                                                                                         |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smith's Chapel Cemetery</b>                                                                                                                                                                                                 |  | 20c. Location - City or Town, State<br><b>Churchville, Maryland</b>                                                                                                                          |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br><b>Kenneth B. Cargo</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 22. Name and Address of Facility<br><b>Tarring-Cargo Funeral Home, P.A.<br/>Aberdeen, Maryland 21001-3399</b>                                                                                                                                                                                            |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              | Approximate Interval Between Onset and Death                                                                                                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b> |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                              |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                    |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                              |  | 28d. Describe how injury occurred                                                                                                                                                            |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                               |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 29b. Signature and Title of Certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                   |  | 29d. Date signed (Month, Day, Year)<br><b>July 5, 2000</b>                                                                                                                                   |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN E. SMIALER 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 6 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                              |                                                                                                                                                                                                  |

0005 JUL 2 1964

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23141

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2028.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Rebecca R. McClung</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <b>7</b> Day <b>6</b> Year <b>00</b>                                                                                                                                |  | 3. Time of Death<br><b>0825</b>                                                                                                                                                                  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Bayview Geriatric Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                      |  | 4c. County of Death<br><b>Baltimore</b>                                                                                                                                                          |  |
| 5. Social Security Number<br><b>234-28-4574</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                                                                              |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 21, 1919</b>                                                                                                                                      |  |
| 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                               |  | 10b. County<br><b>N/A</b>                                                                                                                                                                     |  | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10e. Street and Number<br><b>1119 Hewitt Way</b>                                                                                                                                                                                                                                            |  | 10f. Zip Code<br><b>21205</b>                                                                                                                                                                 |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>                                                                                                                                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Statistician</b>                                                                                                                                                            |  | 16b. Kind of Business/Industry<br><b>Drug Research Company</b>                                                                                                                                |  |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elmer E. Stone</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>O'Dessa Blizzard</b>                                                                                                                  |  |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Samuel R. McClung, Sr. (husband)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1119 Hewitt Way, Baltimore, Maryland 21205</b>                                            |  |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>                                                                                                                                                                                      |  | Date<br><b>7/8/00</b>                                                                                                                                                                         |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home Inc.<br/>3331 Brehms Lane, Baltimore, Maryland 21213</b>                                                                        |  |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Dementia, presumed Picks Type</b><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| Approximate Interval Between Onset and Death<br><b>15 years</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pressure ulcers</b><br><b>Chronic aspiration</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                   |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |  |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>D56054</b>                                                                                                                                                          |  | 29d. Date signed (Month, Day, Year)<br><b>7-6-00</b>                                                                                                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gwen Oldenquist MD, JHBM Geriatric Center, 5505 Hopkins Bayview Cir, Baltimore, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 7 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 32. Registrar's Signature<br>                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 23142

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>LINCOLN (NMN) MCGHEE</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                         |                                        | 2. Date of Death<br>Month <b>July</b> Day <b>8</b> Year <b>2000</b>                                                                                                                          |                                                       | 3. Time of Death<br><b>1:05 P.M.</b>                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>1313 Abingdon Road</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                         |                                        | 4b. City, Town, or Location of Death<br><b>Abingdon</b>                                                                                                                                      |                                                       | 4c. County of Death<br><b>Harford</b>                                            |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>415-32-1294</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                              |                                        | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                                                                                                                                             |                                                       | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 4, 1927</b>                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10e. State<br><b>Maryland</b>                                                                                                                                           |                                        | 10b. County<br><b>Harford</b>                                                                                                                                                                |                                                       | 10c. City, Town or Location<br><b>Abingdon</b>                                   |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                   |  | 10e. Street and Number<br><b>1313 Abingdon Road</b>                                                                                                                     |                                        | 10f. Zip Code<br><b>21009</b>                                                                                                                                                                |                                                       | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean Vietnam</b> |                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                       | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                     |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Military</b>                                            |                                        | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                                                                                                                                     |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>Thomas (nmn) McGhee</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                         |                                        | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minerva Ellen Sutton</b>                                                                                                             |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shizuko O. McGhee/ Wife</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                         |                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1313 Abingdon Rd., Abingdon, MD 21009</b>                                                |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                            |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>                                                                  |                                        | 20c. Location - City or Town, State<br><b>7-11-00 Towson, Maryland</b>                                                                                                                       |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                         |                                        | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, MD 21009</b>                                                                            |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>METASTATIC LUNG Cancer to the BRAIN</b> one year<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. { |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                      |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                       |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                  |                                        | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                       | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                  |                                        | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                       |                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                         | 29c. License number<br><b>D0053536</b> |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>7/10/00</b> |                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DANIEL GROSSMAN MD 1321 Riverside Pkwy Belcamp MD 21017</b>                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                         |                                        |                                                                                                                                                                                              |                                                       |                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                         | 32. Registrar's Signature<br>          |                                                                                                                                                                                              |                                                       |                                                                                  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

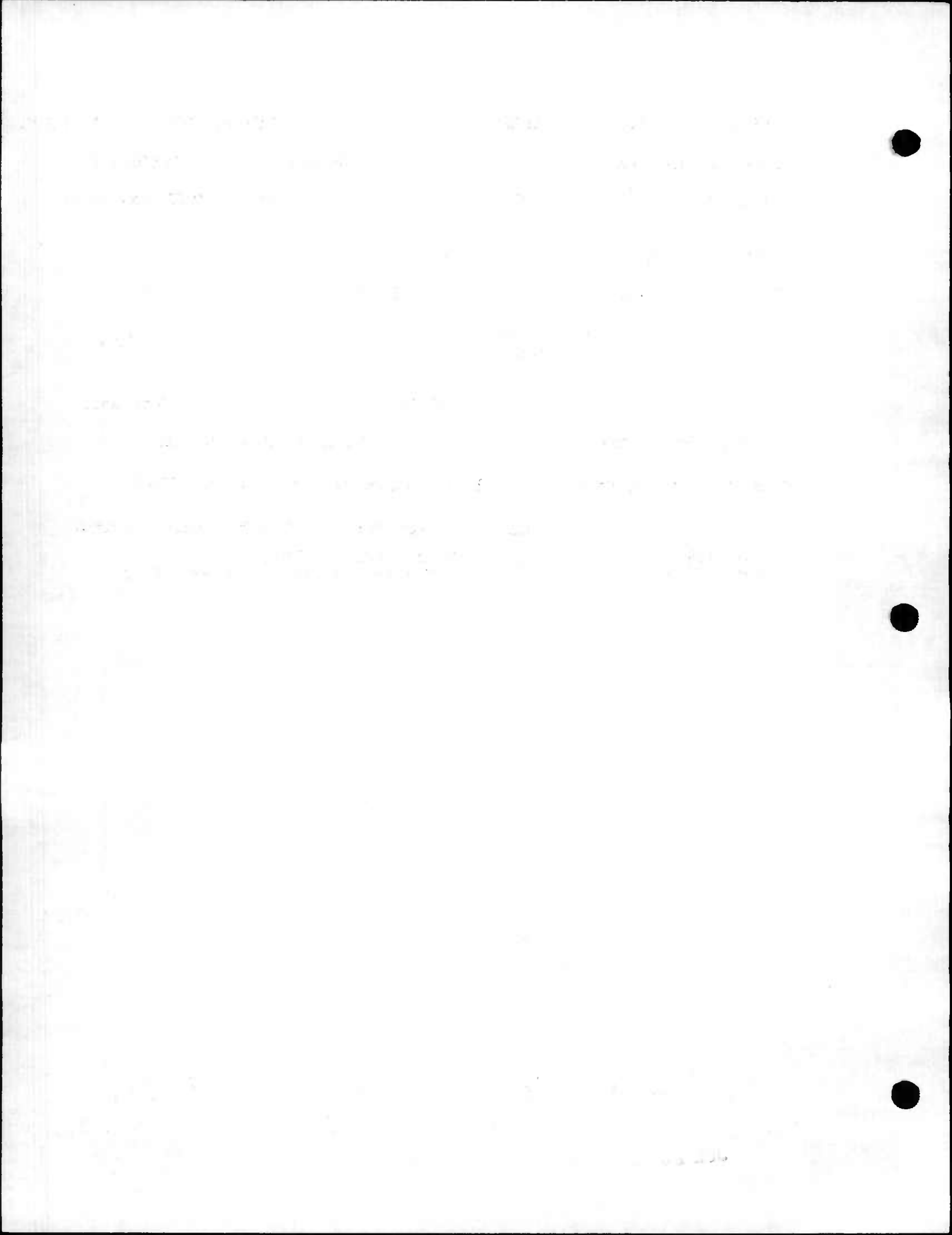
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Amended  
Line 10b.  
7-10-2000  
WCHD SC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23143

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leo Matkins

2. Date of Death

Month Day Year  
July 8 2000

3. Time of Death

1:28AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Williamsport Retirement Village

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

460-64-1346

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
July 31, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

107 Kenilworth Park Drive

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1947-1964

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Stanley Matkins

18. Mother's Name (First, Middle, Maiden Surname)

Veronica Ignatavich

19a. Informant's Name/Relationship (Type, Print)

Penny McDougal/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7731 River Rock Ct. Williamsport, MD 21795

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Indiantown Gap Nat. Cem.

Date

7-11-00

20c. Location - City or Town, State

Annville, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

425 S. Conococheague St.

Williamsport, MD 21795

Osborne Funeral Home

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

b. cerebrovascular disease

Due to (or as a consequence of):

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinsons Disease, Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending Investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cynthia Kuttner-Sands, MD

29c. License number

2477451

29d. Date signed (Month, Day, Year)

July 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Kuttner-Sands MD 11110 Medical Campus Road, Suite 130 Hagerstown, Maryland 21742

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

Frank B. Sparto

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23144

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                                                                                  |  |                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Daniel Maldonado</b>                                                                                                                                                                   |  |                                                                                                                                                   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>11</b> Year <b>2000</b>                                                                                                                                             |  | 3. Time of Death<br><b>0249</b>                                            |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>                                                                                                                                   |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>                                                                                                                                                        |  | 4c. County of Death<br><b>Washington</b>                                   |  |
| 5. Social Security Number<br><b>581-12-8405</b>                                                                                                                                                                                       |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.                                                                                                                                                                 |  | 8. Date of Birth (Month, Day, Year)<br><b>July 13, 1929</b>                |  |
| 9. Birthplace (State or Foreign Country)<br><b>Puerto Rico</b>                                                                                                                                                                        |  | 10a. State<br><b>Maryland</b>                                                                                                                     |  | 10b. County<br><b>Washington</b>                                                                                                                                                                                 |  | 10c. City, Town or Location<br><b>Hagerstown</b>                           |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                        |  | 10e. Street and Number<br><b>17729 Virginia Ave.</b>                                                                                              |  | 10f. Zip Code<br><b>21740</b>                                                                                                                                                                                    |  | 10g. Citizen of What Country?<br><b>United States</b>                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Puerto Rican</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Hispanic</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>0</b>                                                                                                  |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>                          |  | 16b. Kind of Business/Industry<br><b>None</b>                                                                                                                                                                    |  |                                                                            |  |
| 17. Father's Name (First, Middle, Last)<br><b>Pascasio Maldonado</b>                                                                                                                                                                  |  |                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eustaquia Gonzales</b>                                                                                                                                   |  |                                                                            |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rueben Maldonado Son</b>                                                                                                                                                       |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>306 S. Locust St., Hagerstown, Maryland 21740</b>                                                            |  |                                                                            |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Municipal Cemetery</b>                                               |  | Date<br><b>7-16-00</b>                                                                                                                                                                                           |  | 20c. Location - City or Town, State<br><b>Santa Isabel, Puerto Rico</b>    |  |
| 21. Signature of Funeral Service Licensee<br><b>Frank L. Lister</b>                                                                                                                                                                   |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd., Hagerstown, Maryland 21740</b>                                                                                              |  |                                                                            |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Severe Chronic Obstructive Lung Disease</b><br>Due to (or as a consequence of):<br><b>b. possible myocardial infarction</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Approximate Interval Between Onset and Death<br><b>&gt;10 years</b><br><b>&lt;24 hours</b>                                                                                                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |  |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                      |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                           |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br><b>Samuel Chan, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 29c. License number<br><b>D36655</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>                                                                                                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>1185 Mt. Aetna Rd. Hagerstown, MD 21740</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 32. Registrar's Signature<br><b>Benita Sparks</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                  |  |

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MALDONADO, DANIEL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23145

amend item 23a,c per phys. G785 7/21/00 yg

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>WILLIAM H. MOORE, JR.                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            |  | 2. Date of Death<br>Month Day Year<br>April 26 2000                                                                                                                                                 |  | 3. Time of Death<br>1045                                                             |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |  | 4b. City, Town, or Location of Death<br>SALISBURY                                                                                                                                                   |  | 4c. County of Death<br>WICOMICO                                                      |  |
| Funeral<br>Director                           | 5. Social Security Number<br>258-52-9774                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                             |  | 7. Age (In yrs. last birthday)<br>66 Yrs.                                                                                                                                                           |  | 8. Date of Birth (Month, Day, Year)<br>JAN. 31, 1934                                 |  |
|                                               | 9. Birthplace (State or Foreign Country)<br>WAY CROSS, GA.                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10a. State<br>MD.                                                                                                                          |  | 10b. County<br>WORCESTER                                                                                                                                                                            |  | 10c. City, Town or Location<br>BERLIN                                                |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                    |  |                                                                                      |  |
|                                               | 10e. Street and Number<br>113 FLOWER STREET, APT. #8                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            |  | 10f. Zip Code<br>21811                                                                                                                                                                              |  | 10g. Citizen of What Country?<br>USA                                                 |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                         |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                     |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5th                                                                                                                                                                                                                                                                                                                                                             |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LABORER                       |  | 16b. Kind of Business/Industry<br>HORSE-STABLEMAN                                                                                                                                                   |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>WILLIAM H. MOORE, SR.                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ROXIE BROWN                                                                                                                                    |  |                                                                                      |  |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br>LOLA V. SMITH/NIECE                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2114 SPRINGHOLLY DR., DISTRICT HEIGHT, MD. 20747                                                   |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SALISBURY CREMATORY                                              |  | Date<br>5-5-00                                                                                                                                                                                      |  | 20c. Location - City or Town, State<br>SNOWHILL RD., SALIS. MD.                      |  |
|                                               | 21. Signature of Funeral Service Licensee<br>Loretta B. Jolley                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22. Name and Address of Facility<br>JOLLEY MEMORIAL CHAPEL<br>1213 JERSEY ROAD., SALISBURY, MD. 21801                                      |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Respiratory ARREST<br>Due to (or as a consequence of):<br>b. Renal Failure<br>Due to (or as a consequence of):<br>c. SEPTIC SHOCK<br>Due to (or as a consequence of):<br>d. |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|                                               | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                       |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|                                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                        |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                         |  | 28a. Date of Injury (Month, Day Year)                                                                                                      |  | 28b. Time of Injury<br>M                                                                                                                                                                            |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                  |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|                                               | 29b. Signature and title of certifier<br>Frank Arena                                                                                                                                                                                                                                                                                                                                                                                                           |  | 29c. License number<br>D55658                                                                                                              |  | 29d. Date signed (Month, Day, Year)<br>4/26/2000                                                                                                                                                    |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>FRANK ARENA MD. 400 EASTERN SHORE DR. SALISBURY, MD.                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|                                               | 31. Date filed (Month, Day, Year)<br>MAY 02 2000                                                                                                                                                                                                                                                                                                                                                                                                               |  | 32. Registrar's Signature<br>B. Sparks                                                                                                     |  |                                                                                                                                                                                                     |  |                                                                                      |  |

ORIGINAL



Adam Michael Manear

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F

ME0 G787 9-12-00 WR.

Reg. No.

00 23146

Certificate of Death

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Baby Adam Michael Manear</b>                      |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>JULY</b> Day <b>13</b> Year <b>2000</b> |                                                                                                | 3. Time of Death<br><b>11:32 A.M.</b>                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not Institution, give street and number)<br><b>516 North Marlyn Avenue</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Essex</b>                 |                                                                                                | 4c. County of Death<br><b>Baltimore</b>                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>216-57-8014</b>                                                  |                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>0</b> Yrs.                      |                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>March 26, 2000</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                      |                                                                                                                                                   | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                              | 10b. County<br><b>Baltimore</b>                                      |                                                                                                | 10c. City, Town or Location<br><b>Baltimore</b>              |  |
| 10a. Street and Number<br><b>3604 E. Joppa Road</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  | 10f. Zip Code<br><b>21234</b>                                                                                                                     |                                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |                                                                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                              |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                               |                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Infant</b>                        |                                                                            | 16b. Kind of Business/Industry<br><b>N/A</b>                                                                                                                                                 |                                                                      |                                                                                                |                                                              |  |
| 17. Father's Name (First, Middle, Last)<br><b>Scott M. Manear</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                                                                                                                                                   |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emily E. Daugherty</b>                                                                                                               |                                                                      |                                                                                                |                                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. DeWayne Manear (grandfather)</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                   |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1216 Brighton Lane, Bel Air, MD 21014</b>                                                |                                                                      |                                                                                                |                                                              |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>                                                                                                                                                        |                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Maus.</b>                                           |                                                                            | 20c. Location - City or Town, State<br><b>7/17/00 Baltimore, Maryland</b>                                                                                                                    |                                                                      |                                                                                                |                                                              |  |
| 21. Signature of Funeral Service Licensee<br><b>Brian A. Willent</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br><b>Schimunek Funeral Home, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</b>                                                                             |                                                                      |                                                                                                |                                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SUDDEN UNEXPECTED DEATH IN INFANCY</b>                                                                                                                                                                    |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>                                                                                                                  |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                  | 28a. Date of Injury (Month, Day, Year)<br><b>Found: 7-13-00</b>                                                                                   |                                                                            | 28b. Time of A<br><b>11:27 AM</b>                                                                                                                                                            |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                              |  |
| 28d. Describe how injury occurred<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN HOUSE</b>                                   |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>816 N. MARLYN AVE<br/>ESSEX, MD.</b>                                                                      |                                                                      |                                                                                                |                                                              |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
| 29b. Signature and title of certifier<br><b>Joseph Pestaner, MD</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |                                                                                                                                                   |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                       |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>July 14, 2000</b>                                    |                                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                |                                                              |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7-19-00



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State of Maryland / Department of Health and Mental Hygiene

00 23147

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                            |  |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><i>Joseph N. Natoli</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 2. Date of Death<br>Month <i>July</i> Day <i>6</i> Year <i>2000</i>                                                                                                                                                                                                                                                                                                                                                       |  | 3. Time of Death<br><i>3:11 AM</i>                                                                                                                                                                                                                                         |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><i>2945 Daisy Road</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><i>Woodbine</i>                                                                                                                                                                                                                                                                                                                                                                   |  | 4c. County of Death<br><i>Howard</i>                                                                                                                                                                                                                                       |  |
| Funeral<br>Director                           | 5. Social Security Number<br><i>579-48-6193</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><i>65</i> Yrs.                                                                                                                                                                                                                                                                                                                                                                          |  | 8. Date of Birth (Month, Day, Year)<br><i>Sept. 29, 1934</i>                                                                                                                                                                                                               |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><i>Washington, DC</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10a. State<br><i>MD</i>                                                                                                                           |  | 10b. County<br><i>Howard</i>                                                                                                                                                                                                                                                                                                                                                                                              |  | 10c. City, Town or Location<br><i>Woodbine</i>                                                                                                                                                                                                                             |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10e. Street and Number<br><i>2945 Daisy Road</i>                                                                                                  |  | 10f. Zip Code<br><i>21797</i>                                                                                                                                                                                                                                                                                                                                                                                             |  | 10g. Citizen of What Country?<br><i>USA</i>                                                                                                                                                                                                                                |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                             |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                                                                                                                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i></i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Iron Worker</i>                   |  | 16b. Kind of Business/Industry<br><i>Iron</i>                                                                                                                                                                                                                                                                                                                                                                             |  | 17. Father's Name (First, Middle, Last)<br><i>Joseph Natoli</i>                                                                                                                                                                                                            |  |
|                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Catherine Hall</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. Gaynell M. Natoli (Wife)</i>                                                          |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2945 Daisy Road Woodbine, MD 21797</i>                                                                                                                                                                                                                                                                                |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>All County Cremation Serv.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20c. Location - City or Town, State<br><i>Sykesville, MD</i>                                                                                      |  | 21. Signature of Funeral Service Licensee<br><i>Brian D. Haight</i>                                                                                                                                                                                                                                                                                                                                                       |  | 22. Name and Address of Facility<br><i>HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195)<br/>Sykesville, MD 21784 (410)-795-1400</i>                                                                                                                                              |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Metastatic hepatic Carcinoma</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |  | Approximate Interval Between Onset and Death<br><i>4 mo</i>                                                                                       |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
|                                               | 28a. Date of Injury (Month, Day, Year)<br><i>7-6-00</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28b. Time of Injury<br><i>M</i>                                                                                                                   |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>John Kijak Jr. MD</i>                                                                                                                                                                                                          |  |
|                                               | 29c. License number<br><i>D22729 MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br><i>7-6-00</i>                                                                                              |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>John Kijak Jr. MD 9815 Magn St. Damascus MD 20872</i>                                                                                                                                                                                                                                                                          |  | 31. Date filed (Month, Day, Year)<br><i>JUL 10 2000</i>                                                                                                                                                                                                                    |  |
| State Registrar                               | 32. Registrar's Signature<br><i>Berna B. Sparks</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 33. Date of Death<br><i>7-6-00</i>                                                                                                                |  | 34. Date of Burial<br><i>7-6-00</i>                                                                                                                                                                                                                                                                                                                                                                                       |  | 35. Date of Cremation<br><i>7-6-00</i>                                                                                                                                                                                                                                     |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23148

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LLOYD ORSON OBER

2. Date of Death

Month  
JulyDay  
5Year  
2000

3. Time of Death

7:05PM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

107-28-7808

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept 15, 1935

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

NY

10b. County

Dutchess

10c. City, Town or Location

Pawling

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

126 Charles Coleman Boulevard

10f. Zip Code

12564

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technical Designer

16b. Kind of Business/Industry

Electric Company

17. Father's Name (First, Middle, Last)

Orson M. Ober

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Crump

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lorri Stenton (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

126 Charles Coleman Blvd. Pawling, NY 12564

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sand Hill Cemetery

Date

7/10/00

20c. Location - City or Town, State

Dickinson, NY

21. Signature of Funeral Service Licensee

Bryan L. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME &amp; CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Parkinson Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicida4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. H. H.

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/5/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

DR Tariq MAHMOOD 2300 Dulany Valley Rd Towson, MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

J. H. H.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 2025A.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23149

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Perna Mae Phillips                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |                                             | 2. Date of Death<br>Month Day Year<br>07 02 2000                                                                                                                                                 |                                                     |                                                                                      |                                                                  | 3. Time of Death<br>6:18                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Long View Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                             | 4b. City, Town, or Location of Death<br>Manchester                                                                                                                                               |                                                     |                                                                                      |                                                                  | 4c. County of Death<br>Carroll                                                                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>409-54-0439                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |                                             | 7. Age (In yrs. last birthday)<br>93 Yrs.                                                                                                                                                        |                                                     | 8. Date of Birth (Month, Day, Year)<br>May 4, 1907                                   |                                                                  | 9. Birthplace (State or Foreign Country)<br>Kentucky                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. County<br>Baltimore                                                                                                                                                                                                                                                                                |                                             | 10c. City, Town or Location<br>Owings Mills                                                                                                                                                      |                                                     |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>10729 Park Heights Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                             | 10f. Zip Code<br>21117                                                                                                                                                                           |                                                     | 10g. Citizen of What Country?<br>U.S.A.                                              |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                     |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>homemaker                                                                           |                                                     |                                                                                      |                                                                  | 16b. Kind of Business/Industry<br>own home                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Moses Leonard Chambers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dona Moore                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br>Doris P. Pierce/ daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2807 Carlisle Dr. New Windsor, MD 21776                                                         |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Grandview Cemetery                                                                                                                                                                                                            |                                             | Date<br>7/8/00                                                                                                                                                                                   |                                                     | 20c. Location - City or Town, State<br>Maryville, TN                                 |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Catharine O. Hartzler                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                             | 22. Name and Address of Facility<br>Hartzler Funeral Home<br>310 Church St. New Windsor, MD 21776                                                                                                |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebral Thrombosis<br>Due to (or as a consequence of):<br>b. Atherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
| State<br>Registrar                                                                                                                                                                                                                                                                                                                                                                                                            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                 |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                             | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
| 29b. Signature and title of certifier<br>Harold B. Bob                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         | 29c. License number<br>D15872               |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br>July 3, 2000 |                                                                                      |                                                                  |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>25 Main Street Reisterstown Maryland 21136                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                             |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 05 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         | 32. Registrar's Signature<br>Perna B Sparks |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                                  |                                                                                                    |  |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Phillips Perna 7-200 68





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23150

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                                                                                                                                                                    |                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>EDYTHE SIIRI PETERSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                    |                                                                              | 2. Date of Death<br>Month Day Year<br><b>JULY 10, 2000</b>                                                                                                                                                                                                                                  |                                                                                             | 3. Time of Death<br><b>08:45am</b>                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   |                                                                                                                                                                    |                                                                              | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>                                                                                                                                                                                                                             |                                                                                             | 4c. County of Death<br><b>Calvert</b>                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>018-22-9713</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                         |                                                                              | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.                                                                                                                                                                                                                                            |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>November 10, 1929</b>         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   | 10a. State<br><b>Maryland</b>                                                                                                                                      |                                                                              | 10b. County<br><b>Charles</b>                                                                                                                                                                                                                                                               |                                                                                             | 10c. City, Town or Location<br><b>Bryans Road</b>                       |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   | 10e. Street and Number<br><b>2604 Dakota Street</b>                                                                                                                |                                                                              | 10f. Zip Code<br><b>20616</b>                                                                                                                                                                                                                                                               |                                                                                             | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1949-1950</b> |                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                 |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>                                          |                                                                              | 16b. Kind of Business/Industry<br><b>Store</b>                                                                                                                                                                                                                                              |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>James Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                   |                                                                                                                                                                    |                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Siiri Hakkarainen</b>                                                                                                                                                                                                               |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Deborah Albright/Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                   |                                                                                                                                                                    |                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9600 Adams Willett Road, Nanjemoy, Maryland 20662</b>                                                                                                                                   |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cemetery</b>                                                        |                                                                              | 20c. Location - City or Town, State<br><b>Cheltenham, Maryland</b>                                                                                                                                                                                                                          |                                                                                             | Date<br><b>July 14, 2000</b>                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><br><b>M00668</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   | 22. Name and Address of Facility<br><b>Williams Funeral Home, P.A. 20640</b><br><b>4270 Hawthorne Road, Indian Head, Maryland</b>                                  |                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. LOWER GASTRO INTESTINAL BLEEDING. 1 WEEK.</b><br>Due to (or as a consequence of):<br><b>b. UNKNOWN ETIOLOGY. 1 WEEK</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                   |                                                                                                                                                                    |                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEIZURE DISORDER.</b><br><b>DEMENTIA</b><br><b>ANAEMIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                                                                                                                                                                    |                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   |                                                                                                                                                                    |                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                             |                                                                         |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                             |                                                                                                                                                                    | 28b. Time of Injury<br><b>M</b>                                              |                                                                                                                                                                                                                                                                                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                                                                                                                                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                                                                                                                                                                    |                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                         |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                                                                                                                                                                    | 29c. License number<br><b>D 50653</b>                                        |                                                                                                                                                                                                                                                                                             | 29d. Date signed (Month, Day, Year)<br><b>7-11-2000</b>                                     |                                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GYAN - C. SURANA</b><br><b>5851- DEALE CHURCHTON ROAD DEALE MD. 20751</b>                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                                                                                                                                                                    |                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                         |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 32. Registrar's Signature<br> |                                                                                                                                                                    |                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                         |  |





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State of Maryland / Department of Health and Mental Hygiene 00 23151

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br>RUTH IRENE REEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br>July 8, 2000                                                                                                                                                                                                                                                      |                                                                  | 3. Time of Death<br>10:57 A.M.                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br>131 Williams Street                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br>Bel Air                                                                                                                                                                                                                                                         |                                                                  | 4c. County of Death<br>Harford                                                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br>216-01-1657                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                         | 7. Age (In yrs. last birthday)<br>86 Yrs.                                                                                                                                                         |  | 8. Date of Birth (Month, Day, Year)<br>May 9, 1914                                                                                                                                                                                                                                                      |                                                                  | 9. Birthplace (State or Foreign Country)<br>N. Carolina                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                               | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. County<br>Harford                                                                                                                                |                                                                                                                         | 10c. City, Town or Location<br>Bel Air                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                   | 10e. Street and Number<br>131 Williams Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                                                                                                         | 10f. Zip Code<br>21014                                                                                                                                                                            |  | 10g. Citizen of What Country?<br>USA                                                                                                                                                                                                                                                                    |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                       |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                                                                                                                                                                                                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Bookkeeper |                                                                                                                                                                                                   |  | 16b. Kind of Business/Industry<br>State of Maryland                                                                                                                                                                                                                                                     |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 17. Father's Name (First, Middle, Last)<br>Walter Guy Waddell                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Polly Anna Howell                                                                                                                                                                                                                                  |                                                                  |                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Margaret R. Miller, Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1010 Steeples Ct., Falls Church, VA 22046                                                        |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                              |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bel Air Memorial Gardens                                                    |                                                                                                                         |                                                                                                                                                                                                   |  | 20c. Location - City or Town, State<br>7-12-00 Bel Air, Maryland                                                                                                                                                                                                                                        |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 21. Signature of Funeral Service Licensee<br><i>Milly McComas Pennington</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                       |                                                                                                                         | 22. Name and Address of Facility<br>McComas Funeral Home, P.A.<br>50 W. Broadway Street, Bel Air, Maryland 21014                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 23a. Part I. Enter on disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>10 yrs |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                    |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |                                                                                                                         | 28b. Time of Injury<br>M                                                                                                                                                                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                         |                                                                  | 28d. Describe how injury occurred                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                             |  | 29b. Signature and title of certifier<br><i>Attending</i>                                                                                             |                                                                                                                         | 29c. License number<br>D-16444                                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br>JULY 10th 2000                                                                                                                                                                                                                                                   |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>VIJAY S. NAIRM, D. 2112 Belair Road, Fallston MD                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                   | 31. Date filed (Month, Day, Year)<br>JUL 10 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 32. Registrar's Signature<br><i>B. Sparks</i>                                                                                                         |                                                                                                                         |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23152

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAMIE MAE RAY

2. Date of Death

Month Day Year  
July 02 2000

3. Time of Death

1243

4a. Facility Name (If not institution, give street and number)

E.R. Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

204-03-9706

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

6 24

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 9, 1919

9. Birthplace (State or Foreign Country)

Williamson, PA

Usual Residence of Decedent

10a. State

PA

10b. County

Franklin

10c. City, Town or Location

Mont Alto

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

207 University Dr.

10f. Zip Code

17237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

CareGiver

16b. Kind of Business/Industry

Private Homes

17. Father's Name (First, Middle, Last)

William Breneman

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Ketzal

19a. Informant's Name/Relationship (Type, Print)

Donald E. Ray, Sr. son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10220 Calimer Dr., Waynesboro, PA 17268

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Grindstone Hill Cemetery

Date

July 6, 2000

20c. Location - City or Town, State

Guilford Twp. Franklin Co. PA

21. Signature of Funeral Service Licensee

James G. Bouksey

22. Name and Address of Facility

Grove-Bowersox Funeral Home, Inc.

50 South Broad Street Waynesboro, PA 17268

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

ACUTE RENAL FAILURE

2 DAYS

Due to (or as a consequence of):

b.

SEPTIC SHOCK

2 DAYS

Due to (or as a consequence of):

c.

ISCHEMIC BOWEL DISEASE

unknown

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

ATHRO SCLEROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Malik

29c. License number

D44996

29d. Date signed (Month, Day, Year)

JULY 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zafar Malik MD 20311 Lappans Rd Boonsboro, MD 21713

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 06 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Ray, Mamie Mae



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23153

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                     |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>FRANKLIN J. RODERICK                    |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     | 2. Date of Death<br>Month Day Year<br>JULY 4, 2000                                   |                                                             | 3. Time of Death<br>10:43 PM                                                                       |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>SUBURBAN HOSPITAL |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     | 4b. City, Town, or Location of Death<br>BETHESDA                                     |                                                             | 4c. County of Death<br>MONTGOMERY                                                                  |                                                           |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>236-46-1330                                            |                                                                              | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                        |                                           | 7. Age (In yrs. last birthday)<br>67 Yrs.                                                                                                                                                           |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>6/11/1933            |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>WEST VIRGINIA |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                         |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     | 10b. County<br>WASHINGTON                                                    |                                                                                                                                                       | 10c. City, Town or Location<br>HAGERSTOWN |                                                                                                                                                                                                     |                                                                                      |                                                             | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                           |  |
| 10e. Street and Number<br>12 S. WALNUT ST., APT. 508                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     |                                                                              |                                                                                                                                                       |                                           | 10f. Zip Code<br>21740                                                                                                                                                                              |                                                                                      | 10g. Citizen of What Country?<br>USA                        |                                                                                                    |                                                           |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                             |                                                                                     |                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |                                                           |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                     |                                                                              |                                                                                                                                                       |                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>AIDE                                                                                   |                                                                                      |                                                             | 16b. Kind of Business/Industry<br>HOSPITAL                                                         |                                                           |  |
| 17. Father's Name (First, Middle, Last)<br>THOMAS RODERICK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     |                                                                              |                                                                                                                                                       |                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY JENKINS                                                                                                                                   |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>ROBERT F. RODERICK/BROTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                     |                                                                              |                                                                                                                                                       |                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>515 W. STEPHENS ST., MARTINSBURG, WV 25401                                                         |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                    |                                                                                     |                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SMITHSBURG CREMATORY                                                        |                                           | Data<br>7/7/00                                                                                                                                                                                      |                                                                                      | 20c. Location - City or Town, State<br>SMITHSBURG, MARYLAND |                                                                                                    |                                                           |  |
| 21. Signature of Funeral Service Licensee<br>Charles M. Brown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                              |                                                                                                                                                       |                                           | 22. Name and Address of Facility<br>BROWN FUNERAL HOME, 327 W. KING ST.,<br>PO BOX 821, MARTINSBURG, WV 25402                                                                                       |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. SHOCK<br>Due to (or as a consequence of):<br>SEVERE CONGESTIVE HEART FAILURE<br>b. SEVERE CARDIOMYOPATHY<br>Due to (or as a consequence of):<br>CORONARY DISEASE<br>c. d.<br>Approximate Interval Between Onset and Death<br>HOURS<br>MONTHS<br>MONTHS<br>YEARS |                                                                                     |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                     |                                                                              |                                                                                                                                                       |                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                         |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                     |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                            |                                                                                     |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida                                                                                                                                                                                                                                                          |                                                                                     | 28a. Date of Injury (Month, Day Year)                                        |                                                                                                                                                       | 28b. Time of Injury<br>M                  |                                                                                                                                                                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                             | 28d. Describe how Injury occurred                                                                  |                                                           |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                   |                                                                                     |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 29b. Signature and title of certifier<br>B. Sparks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                     |                                                                              |                                                                                                                                                       |                                           | 29c. License number<br>D38091                                                                                                                                                                       |                                                                                      | 29d. Date signed (Month, Day, Year)<br>7/5/00               |                                                                                                    |                                                           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>BRIAN LEWIS, MD 5454 WISCONSIN AVE., SUITE 640, CHEVY CHASE, MD 20815                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                              |                                                                                                                                                       |                                           |                                                                                                                                                                                                     |                                                                                      |                                                             |                                                                                                    |                                                           |  |
| 31. Date filed (Month, Day, Year)<br>JUL 07 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                              |                                                                                                                                                       |                                           | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                              |                                                                                      |                                                             |                                                                                                    |                                                           |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2500 WK

Certificate of Death

00 23154

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM RUMGAY SR.</b>                                                                                                                                                                                                                                                                                                                                          |  | 2. Date of Death<br>Month <b>July</b> Day <b>06</b> Year <b>2000</b>                                                                                                           |  | 3. Time of Death<br><b>4:30 P.M.</b>                                                                                                                             |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>4 Walker Road 6 WALKER RD.</b>                                                                                                                                                                                                                                                                                                            |  | 4b. City, Town, or Location of Death<br><b>La Vale</b>                                                                                                                         |  | 4c. County of Death<br><b>Allegany</b>                                                                                                                           |  |
| 5. Social Security Number<br><b>580-86-2668</b>                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                     |  | 7. Age (In yrs. last birthday)<br><b>58</b>                                                                                                                      |  |
| 8. Data of Birth (Month, Day, Year)<br><b>May 1, 1942</b>                                                                                                                                                                                                                                                                                                                                                      |  | 9. Birthplace (State or Foreign Country)<br><b>Puerto Rico</b>                                                                                                                 |  |                                                                                                                                                                  |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. County<br><b>Allegany</b>                                                                                                                                                 |  | 10c. City, Town or Location<br><b>LaVale</b>                                                                                                                     |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                 |  | 10e. Street and Number<br><b>6 Walker Road</b>                                                                                                                                 |  | 10f. Zip Code<br><b>21502</b>                                                                                                                                    |  |
| 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Vietnam</b> |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Puerto Rican Hispanic</b>                                                                                                                                                                                     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Hispanic</b>                                                                                                     |  |                                                                                                                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega</b>                                                                                                                                                                                                                                                                    |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Military Police</b>                                            |  | 16b. Kind of Business/Industry<br><b>Military</b>                                                                                                                |  |
| 17. Father's Name (First, Middle, Last)<br><b>William A. Rungay</b>                                                                                                                                                                                                                                                                                                                                            |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Teresa Ferrer</b>                                                                                                |  |                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maria Rungay?wife</b>                                                                                                                                                                                                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 Walker Road, LaVale, MD 21502</b>                                        |  |                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                          |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rocky Gap Veterans Cemetery</b>                                                                   |  | 20c. Location - City or Town, State<br><b>10,2000 Flintstone, MD</b>                                                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                |  | 22. Name and Address of Facility<br><b>Hafer Chapel of the Hills Mortuary<br/>1302 National Hwy, LaVale, MD 21502</b>                                                          |  | Approximate Interval Between Onset and Death                                                                                                                     |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>                                                                                                                                        |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                               |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>                                                                                                    |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                        |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 28a. Date of Injury (Month, Day Year)<br><b>July 06 2000</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 29d. Date signed (Month, Day, Year)<br><b>July 07, 2000</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACK M. TIMS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 20 2000</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                |  |                                                                                                                                                                  |  |

To Be Completed by Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

State Registrar



B.K.S

JOANNA L. RUSSO

AMEND ITEMS: #23 PART I, 27, 28A-F PER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23155

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1. Decedent's Name (First, Middle, Last)<br>JoAnna L. Russo                                      |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          | 2. Date of Death<br>Month Day Year<br>JULY 14, 2000  |                                                                                                    |                                                      | 3. Time of Death<br>2107 PM                                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          | 4b. City, Town, or Location of Death<br>ROCKVILLE    |                                                                                                    |                                                      | 4c. County of Death<br>MONTGOMERY                                                                                                                                                                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 5. Social Security Number<br>219-19-3933                                                         |                      | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>15 Yrs.                                                                                                                                                        |                                                                                                                                          | 8. Date of Birth (Month, Day, Year)<br>July 28, 1984 |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Usual Residence of Decedent                                                                      |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 10a. State<br>PA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  | 10b. County<br>Adams |                                                                                                                                                       | 10c. City, Town or Location<br>Littlestown                                                                                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                                                          |                                                      | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      |                                                                                                                                                                                                          |  |
| 10e. Street and Number<br>127 East King St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 10f. Zip Code<br>17340                                                                                                                   |                                                      | 10g. Citizen of What Country?<br>USA                                                               |                                                      |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                      | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                          |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                      |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>9 Elementary/Secondary (0-12) College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                      |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Student                                                                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                          |                                                      | 16b. Kind of Business/Industry<br>Public School                                                    |                                                      |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>George N. Russo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Patricia S. King                                                                    |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Patricia S. King (Mother)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>127 East King St. Littlestown, PA 17340 |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  |                      |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Carmel Cemetery                                                                                                                                                                                                           |                                                                                                                                                                                                  | Date<br>7/21/00                                                                                                                          |                                                      | 20c. Location - City or Town, State<br>Littlestown, PA                                             |                                                      |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 22. Name and Address of Facility<br>Little's F.H. 34 Maple Ave. Littlestown, PA 17340                                                    |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. GUNSHOT WOUND OF CHEST<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                      |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                      |                                                                                                                                                       | 28a. Date of Injury (Month, Day, Year)<br>7-14-00                                                                                                                                                                                                                                                       |                                                                                                                                                                                                  | 28b. Time of Injury<br>8:20 M                                                                                                            |                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |                                                      | 28d. Describe how injury occurred<br>SUBJECT WAS SHOT                                                                                                                                                    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>APARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Rd. APT. #304 GAITHERSBURG, MD                           |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                            |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      | 29c. License number<br>O.C.M.E                                                                                                                                                                           |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br>JULY 15, 2000                                                                                     |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |                      |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 20 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                      |                                                                                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                  |                                                                                                                                          |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |



JAMES  
RAYNER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23156

## Certificate of Death

Reg. No.

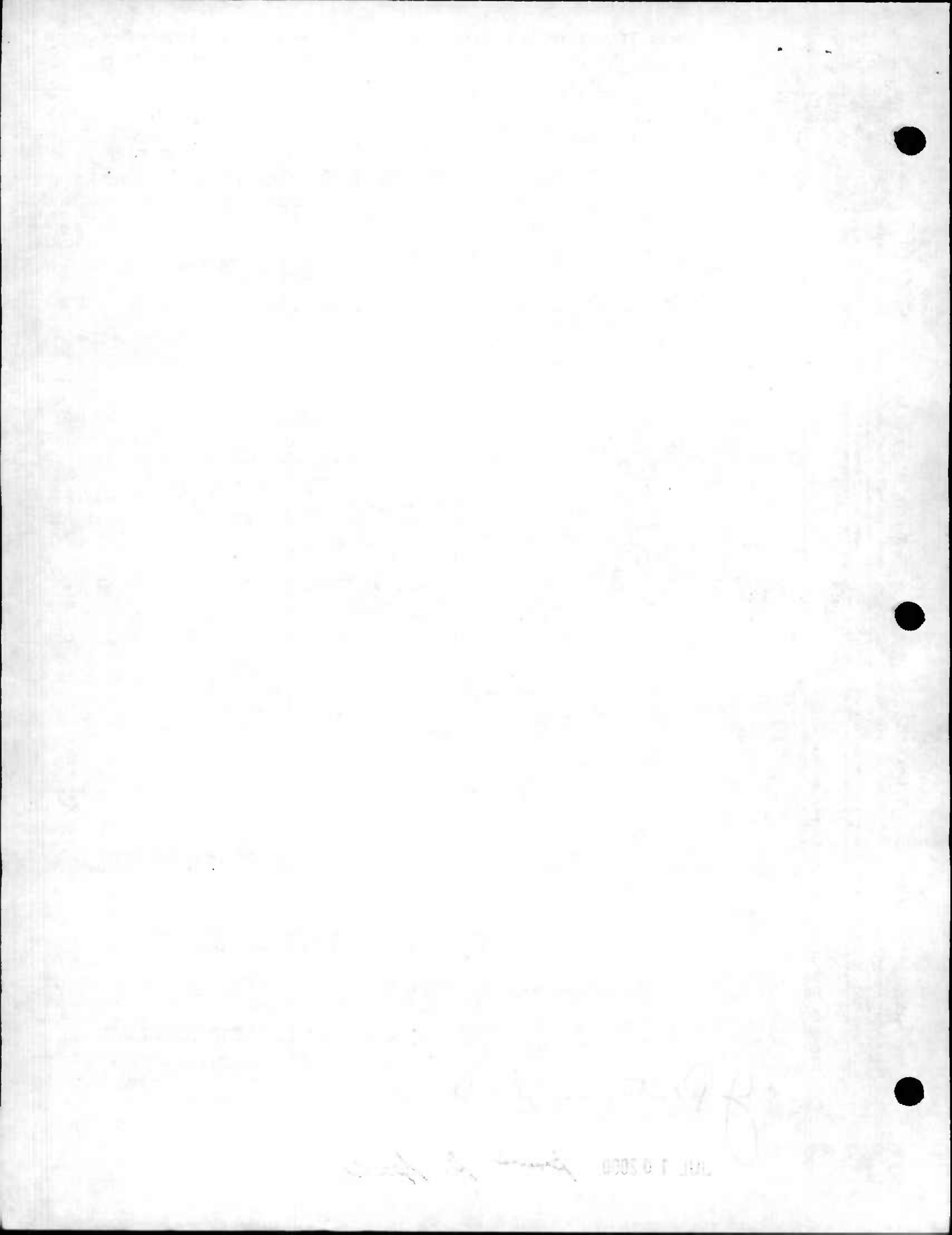
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                         |                                |                                                                                                                             |                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>James Rayner</b>                                      |                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                  | 2. Date of Death<br>Month <b>JULY</b> Day <b>5</b> , Year <b>2000</b>                                                                   |                                | 3. Time of Death<br><b>2:49P.M.</b>                                                                                         |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>DORCHESTER GENERAL HOSPITAL</b> |                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                  | 4b. City, Town, or Location of Death<br><b>CAMBRIDGE</b>                                                                                |                                | 4c. County of Death<br><b>DORCHESTER</b>                                                                                    |                                                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>235-14-6664</b>                                                      |                                                                                                                                                                                                                                                                                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. |                                                                                                                                         | If Under 1 Year<br>Months Days |                                                                                                                             | If Under 24 Hrs.<br>Hours Min.                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>May 4, 1921</b>                                            |                                                                                                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10a. State<br><b>Maryland</b>                    |                                                                                                                                         | 10b. County<br><b>Somerset</b> |                                                                                                                             | 10c. City, Town or Location<br><b>Marion Station</b> |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                           |                                                                            | 10e. Street and Number<br><b>4339 Paul Gumbo Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                  | 10f. Zip Code<br><b>21838</b>                                                                                                           |                                | 10g. Citizen of What Country?<br><b>US</b>                                                                                  |                                                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                 |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) |                                                      |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b>                                                                                                                                                                                                                                                                                             |                                                                                                      | 16b. Kind of Business/Industry<br><b>Steel Mill</b>                                                                                                                                                                                                                                      |                                                                            | 17. Father's Name (First, Middle, Last)<br><b>James Rayner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosella Fischer</b>                                                             |                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>Pauline M. Rayner Wife</b>                                           |                                                      |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7246 Oliver Beach RD Baltimore, Maryland 21220</b>                                                                                                                                                                                                                                                                       |                                                                                                      | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                    |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Lawn Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  | Date<br><b>7/8/00</b>                                                                                                                   |                                | 20c. Location - City or Town, State<br><b>Cambridge, Maryland</b>                                                           |                                                      |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      | 22. Name and Address of Facility<br><b>Thomas Funeral Home, P.A.<br/>700 Locust Street Cambridge, Maryland 21613</b>                                                                                                                                                                     |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypertensive Arteriosclerotic Cardiovascular Disease</b> Months<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                  | Approximate Interval Between Onset and Death                                                                                            |                                |                                                                                                                             |                                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |                                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                         |                                                                            | 24a. Was an autopsy performed?<br><b>INSPECTION</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                |                                                                                                                             |                                                      |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                  | 28a. Date of Injury (Month, Day Year)                                                                                                   |                                | 28b. Time of Injury<br><b>M</b>                                                                                             |                                                      |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                             |                                                                                                      | 28d. Describe how injury occurred                                                                                                                                                                                                                                                        |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                            |                                |                                                                                                                             |                                                      |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                      | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 29d. Date signed (Month, Day, Year)<br><b>JULY 6, 2000</b>                                                                              |                                |                                                                                                                             |                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH PESTANER MD. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                |                                                                                                      | 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                  |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                  | State Registrar                                                                                                                         |                                |                                                                                                                             |                                                      |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

00 23157

amend item 5 per G788 10/3/00 yf

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>MARILAIN PATTON ROCKHILL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 2. Date of Death<br>Month Day Year<br><b>JULY 5, 2000</b>                                                                                                 |                                                                 | 3. Time of Death<br><b>10:00 p.m.</b>                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris at Mercy Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                  |                                                                 | 4c. County of Death<br><b>Baltimore City</b>                                                                                                                                                 |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>215-46-1984</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.                                                                                                          | 8. Date of Birth (Month, Day, Year)<br><b>DECEMBER 31, 1944</b> | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10b. County<br><b>CALVERT</b>                                              | 10c. City, Town or Location<br><b>ST. LEONARD</b>                                                                                                         |                                                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>6500 LONG BEACH DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 10f. Zip Code<br><b>20685-2540</b>                                                                                                                        |                                                                 | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:         |                                                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>                      |                                                                 |                                                                                                                                                                                              |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 16b. Kind of Business/Industry<br><b>Board of Education</b>                                                                                               |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>MALCOLM ERWIN ROCKHILL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EUNICE PEARL LEWIS</b>                                                                            |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>C. MICHELE ROCKHILL sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6500 LONG BEACH DRIVE, ST. LEONARD, MARYLAND 2540</b> |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                                   |                                                                 | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>                                                                                                                           |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 21. Signature of Funeral Service Licensee<br><b>Charles F. Bell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.<br/>Owings, Maryland 20736</b>                                                           |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death)</b><br><b>RENAL FAILURE</b><br>Due to (or as a consequence of):<br><b>DIABETES</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Peripheral Vascular Disease</b><br><b>Congestive Heart Failure</b> |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 26. Place of Death (Check only one) <b>STELLA MARIS at Mercy</b><br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b> Hospice</b>                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
| State<br>Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                           |                                                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                    |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29b. Signature and title of certifier<br><b>Dr. [Signature] MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | 29c. License number<br><b>D40854</b>                                                                                                                      |                                                                 | 29d. Date signed (Month, Day, Year)<br><b>July 6, 2000</b>                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID RISEBERG 301 ST Paul Pl BALTIMORE MD 21202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 32. Registrar's Signature<br><b>[Signature]</b>                            |                                                                                                                                                           |                                                                 |                                                                                                                                                                                              |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23158

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------|--|-------------------------------|----------------------------------|-------|--------------------------------|----------------------------------|-------|-----------------------|----------------------------------|-------|---------------------------------------------|----------------------------------|-------|
| Physician /Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Sterling Edward Schaefer</b>                            |  |                                                                                                                                                      |                                                                                                                                                    | 2. Date of Death<br>Month <b>07</b> Day <b>01</b> Year <b>00</b>             |                                                                         | 3. Time of Death<br><b>9:41 AM</b>                          |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  | 4a. Facility Name (If not institution, give street and number)<br><b>Carroll Co. General Hospital</b>  |  |                                                                                                                                                      |                                                                                                                                                    | 4b. City, Town, or Location of Death<br><b>Westminster</b>                   |                                                                         | 4c. County of Death<br><b>Carroll</b>                       |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 5. Social Security Number<br><b>218-32-6344</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 6. Sex<br><b>1</b> M <b>2</b> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.                                                                                                     |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>02-16-36</b>                       |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  | 10b. County<br><b>CARROLL</b>                                                                          |  | 10c. City, Town or Location<br><b>WESTMINSTER</b>                                                                                                    |                                                                                                                                                    |                                                                              |                                                                         | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No         |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 10a. Street and Number<br><b>723 WASHINGTON RD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                        |  | 10f. Zip Code<br><b>21157</b>                                                                                                                        |                                                                                                                                                    | 10g. Citizen of What Country?<br><b>USA</b>                                  |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                                                                                                                                                                                                                                                                                                                                                            |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |                                                                                                                                                    |                                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BUYER</b>                            |                                                                                                                                                    |                                                                              | 16b. Kind of Business/Industry<br><b>ENGINEERING</b>                    |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 17. Father's Name (First, Middle, Last)<br><b>ELMER STERLING SCHAEFER</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                  |                                                                                                        |  |                                                                                                                                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LORAIN PEELING</b>                                                                         |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PATRICIA SCHAEFER -WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                  |                                                                                                        |  |                                                                                                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>723 WASHINGTON RD., WESTMINSTER, MD. 21157</b> |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                                                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>EVERGREEN MEM. GARDENS</b>                                              |                                                                                                                                                    | 20c. Location - City or Town, State<br><b>7/6/00 FINKSBURG, MD.</b>          |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                        |  | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME</b><br><b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>                                   |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                      |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| <table border="0"> <tr> <td>a. <b>Respiratory Failure</b></td> <td>Due to (or as a consequence of):</td> <td>Hours</td> </tr> <tr> <td>b. <b>Aspiration Pneumonia</b></td> <td>Due to (or as a consequence of):</td> <td>Hours</td> </tr> <tr> <td>c. <b>Hematemesis</b></td> <td>Due to (or as a consequence of):</td> <td>Hours</td> </tr> <tr> <td>d. <b>Innominate Artery Enteric Fistula</b></td> <td>Due to (or as a consequence of):</td> <td>Hours</td> </tr> </table> |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  | a. <b>Respiratory Failure</b> | Due to (or as a consequence of): | Hours | b. <b>Aspiration Pneumonia</b> | Due to (or as a consequence of): | Hours | c. <b>Hematemesis</b> | Due to (or as a consequence of): | Hours | d. <b>Innominate Artery Enteric Fistula</b> | Due to (or as a consequence of): | Hours |
| a. <b>Respiratory Failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due to (or as a consequence of): | Hours                                                                                                  |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| b. <b>Aspiration Pneumonia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Due to (or as a consequence of): | Hours                                                                                                  |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| c. <b>Hematemesis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Due to (or as a consequence of): | Hours                                                                                                  |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| d. <b>Innominate Artery Enteric Fistula</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    | Due to (or as a consequence of): | Hours                                                                                                  |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| <b>S/R Esophago gastrectomy for Esophageal Cancer</b><br><b>S/R Migration and Division Innominate Artery and Cervical Esophagus</b>                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)                                                                                                                                                                                                                                                                                               |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide                                                                                                                                                                                                                                                                                                             |                                  | 28a. Date of Injury (Month, Day, Year)                                                                 |  | 28b. Time of Injury<br><b>M</b>                                                                                                                      |                                                                                                                                                    | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                             |                                                                         | 28d. Describe how injury occurred                           |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                 |  |                                                                                                                                                      |                                                                                                                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                 |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  |                                                                                                        |  | 29c. License number<br><b>MD 00020554</b>                                                                                                            |                                                                                                                                                    | 29d. Date signed (Month, Day, Year)<br><b>7/1/2000</b>                       |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert Gordon 122 Slade Ave. Suite 101 Baltimore, Md. 21208</b>                                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                        |  |                                                                                                                                                      |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                |  | 32. Registrar's Signature<br>                                                                                                                        |                                                                                                                                                    |                                                                              |                                                                         |                                                             |  |                               |                                  |       |                                |                                  |       |                       |                                  |       |                                             |                                  |       |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23159

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELDA S.

SICHELSTIEL

2. Date of Death

Month Day Year  
JULY 3, 2000

3. Time of Death

11:10 PM

4a. Facility Name (If not institution, give street and number)

LONG VIEW NURSING HOME

4b. City, Town, or Location of Death

MANCHESTER

4c. County of Death

CARROLL

Funeral  
Director

5. Social Security Number

216-14-6996

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 8, 1920

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

807 LUCABAUGH MILL RD.

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME MAKING

17. Father's Name (First, Middle, Last)

RAYMOND E. SHRIVER

18. Mother's Name (First, Middle, Maiden Surname)

NETTIE E. COULSON

19a. Informant's Name/Relationship (Type, Print)

RICHARD F. SICHELSTIEL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

807 LUCABAUGH MILL RD., WESTMINSTER, MD. 21157

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVERGREEN MEM. GARDENS 7/7/00 FINKSBURG, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FLETCHER FUNERAL HOME  
254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):b. leukemia  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate interval Between Onset and Death

1 week

30 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H0052241

29d. Date signed (Month, Day, Year)

07-06-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GENINE CONSAGRA-RIGGINS 688 C POPE RD WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year)

JUL 07 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23160

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael John Stollmeyer

2. Date of Death

Month  
JulyDay  
6Year  
2000

3. Time of Death

1:30 PM

4a. Facility Name (If not Institution, give street and number)

Westminster Nursing Home

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

121-07-3741

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 16 1914 New York

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2471 Grimville Road

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2 years

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Purchasing Agent

16b. Kind of Business/Industry

Bank

17. Father's Name (First, Middle, Last)

John Stollmeyer

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Lynch

19a. Informant's Name/Relationship (Type, Print)

Michele Kim Lewis Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2471 Grimville Road Mt. Airy, MD 21771

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation, Inc.

Date

7/8/00

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.

1212 W. Old Liberty Road Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Oesophageal Cancer

Due to (or as a consequence of):

b. Aspiration Pneumonia

Due to (or as a consequence of):

c. Renal failure

Due to (or as a consequence of):

d. Anaemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 0054218

29d. Date signed (Month, Day, Year)

07-07-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RAMAN B. KANERPA, 419-F Malcolm Avenue Westminister MD 21157

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

Raman B Kanerpa

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

James B. G.



00-3699-510

JAMES

SPICER JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23161

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br>James Douglas Spicer, Jr.                    |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br>JULY 5, 2000 |                                                                                             | 3. Time of Death<br>3:20P.M.                                                                   |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br>JOHNS HOPKINS HOSPITAL |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br>BALTIMORE  |                                                                                             | 4c. County of Death<br>---                                                                     |                                                      |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br>217-45-3583                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br>4 Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                                                                                                              | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth (Month, Day, Year)<br>Oct. 21, 1995                                        |                                                                                                | 9. Birthplace (State or Foreign Country)<br>Maryland |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Usual Residence of Decedent                                                              |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          | 10b. County<br>Harford                                                                                                                            |                                          | 10c. City, Town or Location<br>Joppa                                                                                                                                                                                                                                                        |                                                    |                                                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                      |
| 10e. Street and Number<br>1407 A Philadelphia Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          |                                                                                                                                                   |                                          | 10f. Zip Code<br>21085                                                                                                                                                                                                                                                                      |                                                    | 10g. Citizen of What Country?<br>USA                                                        |                                                                                                |                                                      |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |                                                    |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |                                                      |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                                                                                                                                   |                                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Child- never worked                                                                                                                                                            |                                                    |                                                                                             | 16b. Kind of Business/Industry                                                                 |                                                      |
| 17. Father's Name (First, Middle, Last)<br>James Douglas Spicer, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                          |                                                                                                                                                   |                                          | 18. Mother's Name (First, Middle, Maiden Surname)<br>Crystal Lynn Missos                                                                                                                                                                                                                    |                                                    |                                                                                             |                                                                                                |                                                      |
| 19a. Informant's Name/Relationship (Type, Print)<br>James D. Spicer, Sr.-father                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                   |                                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1407 A Philadelphia Road, Joppa, Maryland 21085                                                                                                                                            |                                                    |                                                                                             |                                                                                                |                                                      |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                          |                                                                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Trinity Lutheran Church Cen.                                            |                                          |                                                                                                                                                                                                                                                                                             | Date<br>7/8/2000                                   |                                                                                             | 20c. Location - City or Town, State<br>Joppa, Maryland                                         |                                                      |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          |                                                                                                                                                   |                                          | 22. Name and Address of Facility<br>McComas Funeral Home, P.A.<br>1317 Cokesbury Road, Abingdon, Maryland 21009                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Drowning</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                          |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                          |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          |                                                                                                                                                   |                                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                    |                                                                                             |                                                                                                |                                                      |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                        |                                                                                          | 28a. Date of Injury (Month, Day Year)<br>7-05-2000 unknown                                                                                        |                                          | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                    |                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred<br>Subject drowned |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>Rocky Point Park                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                          |                                                                                                                                                   |                                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Baltimore County, Maryland                                                                                                                                                                                  |                                                    |                                                                                             |                                                                                                |                                                      |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                   |                                                                                          |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          |                                                                                                                                                   |                                          | 29c. License number<br>O.C.M.E.                                                                                                                                                                                                                                                             |                                                    | 29d. Date signed (Month, Day, Year)<br>JULY 6, 2000                                         |                                                                                                |                                                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          |                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                             |                                                                                                |                                                      |
| 31. Date filed (Month, Day, Year)<br>JUL 7 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                   |                                          | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                    |                                                                                             |                                                                                                |                                                      |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, DC

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23162

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fred Joseph Simmons

2. Date of Death

Month Day Year  
July 5, 2000

3. Time of Death

1800

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

247-40-7557

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 1, 1929

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

544 Bonnie Drive

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1946-69

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Military

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Orr Simmons

18. Mother's Name (First, Middle, Maiden Surname)

Julie Durham

19a. Informant's Name/Relationship (Type, Print)

Emo Jean Simmons (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

544 Bonnie Drive, Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Mem. Gdns. Mausoleum

Date

7/8/00

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

Kenneth B. Gump

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio respiratory Failure

Due to (or as a consequence of):

b. Liver cirrhosis

Due to (or as a consequence of):

c. Asbestos

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. T. Lee MD

29c. License number

P 20661

29d. Date signed (Month, Day, Year)

7/6/00

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

J. T. Lee MD 669 Revolution St Havre de Grace MD 21078

31. Date filed (Month, Day, Year)

JUL 7 2000

32. Registrar's Signature

B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, B#



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

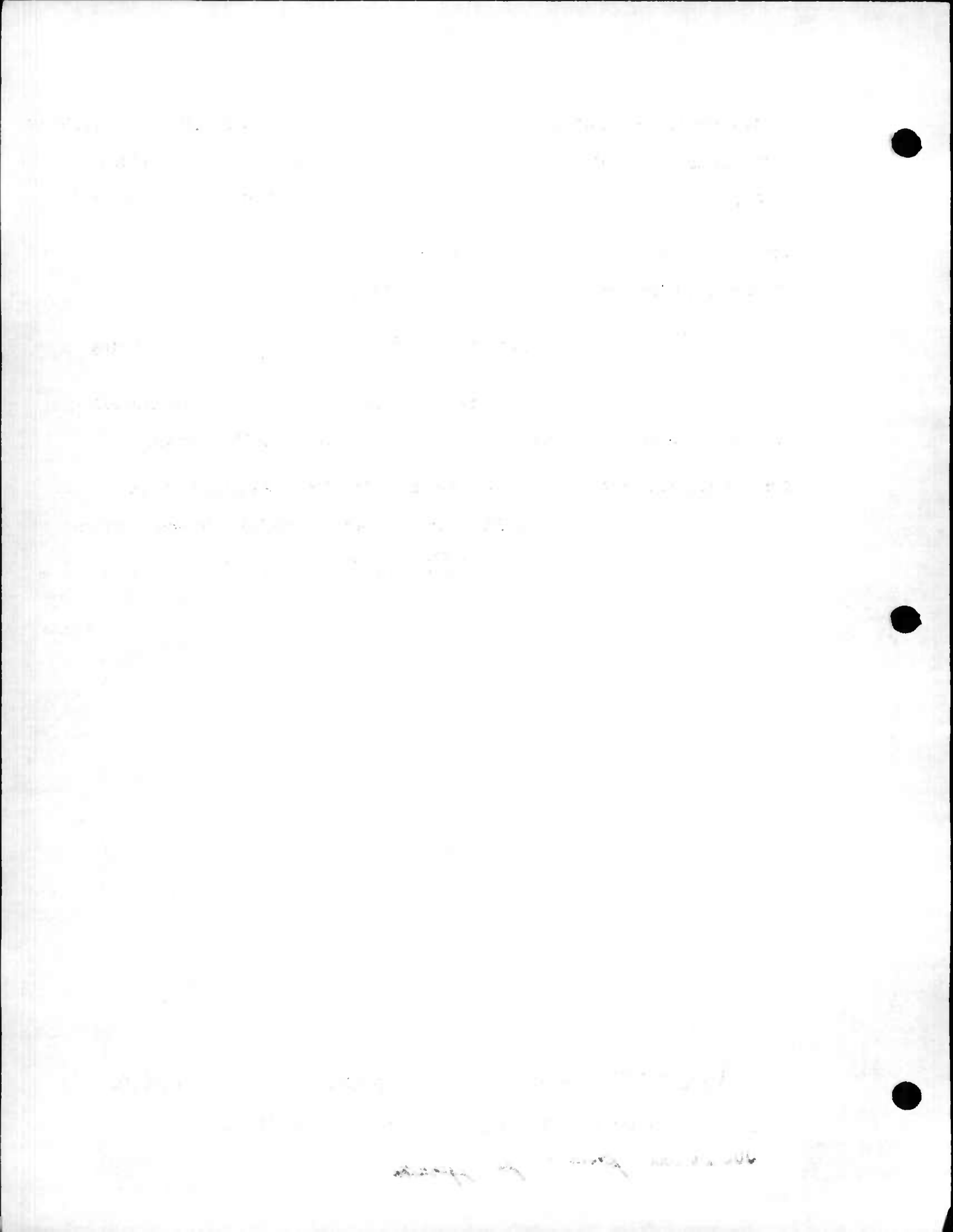
State of Maryland / Department of Health and Mental Hygiene

00 23163

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                             |  |                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Phillip Arthur Sterling</b>                                                                                                                                                            |  |                                                                            |  | 2. Date of Death<br>Month <b>July</b> Day <b>6</b> Year <b>2000</b>                                                                                                                                                                                                                         |  |                                                             |  | 3. Time of Death<br><b>10:10 AM</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>404 Cedar Spring Rd.</b>                                                                                                                                         |  |                                                                            |  | 4b. City, Town, or Location of Death<br><b>Bel Air</b>                                                                                                                                                                                                                                      |  |                                                             |  | 4c. County of Death<br><b>Harford</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-26-4091</b>                                                                                                                                                                                       |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>70</b> yrs.                                                                                                                                                                                                                                            |  | 8. Date of Birth (Month, Day, Year)<br><b>June 24, 1930</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                  |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                           |  |                                                                            |  | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                               |  | 10b. County<br><b>Harford</b>                               |  | 10c. City, Town or Location<br><b>Bel Air</b>                                                                                                                                                                                                                                                                                                                                                                                |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                        |  |                                                                            |  | 10e. Street and Number<br><b>404 Cedar Spring Road</b>                                                                                                                                                                                                                                      |  |                                                             |  | 10f. Zip Code<br><b>21015</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |
|                                               | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                           |  |                                                                            |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                              |  |                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1948-52</b>                                                                                                                                                                                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>                            |  |                                                                            |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                     |  |                                                             |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                  |  |
|                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner/Operator</b>                                                                                                    |  |                                                                            |  | 16b. Kind of Business/Industry<br><b>Carpet Installation</b>                                                                                                                                                                                                                                |  |                                                             |  | 17. Father's Name (First, Middle, Last)<br><b>Sidney (u/k) Sterling</b>                                                                                                                                                                                                                                                                                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lois (u/k) Moore</b>                                                                                                                                                          |  |                                                                            |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Corinne Sterling - Wife</b>                                                                                                                                                                                                          |  |                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>404 Cedar Spring Road, Bel Air, Maryland 21015</b>                                                                                                                                                                                                                                                                       |  |
|                                               | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |                                                                            |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>                                                                                                                                                                                      |  |                                                             |  | 20c. Location - City or Town, State<br><b>7/8/00 Towson, Maryland</b>                                                                                                                                                                                                                                                                                                                                                        |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                         |  |                                                                            |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.</b><br><b>1317 Cokesbury Road, Abingdon, Maryland 21009</b>                                                                                                                                                               |  |                                                             |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic Pancreatic Cancer</b>                                                                                                                                                                              |  |
|                                               | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  |                                                                            |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |  |                                                             |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                     |  |                                                                            |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                             |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                  |  |
|                                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                |  |                                                                            |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                             |  |                                                             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                     |  |                                                                            |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                             |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|                                               | 29b. Signature and title of certifier<br>M.D.                                                                                                                                                                                         |  |                                                                            |  | 29c. License number<br><b>045390</b>                                                                                                                                                                                                                                                        |  |                                                             |  | 29d. Date signed (Month, Day, Year)<br><b>7/7/00</b>                                                                                                                                                                                                                                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GIA W. MACPHAIL RD # 212, BEL AIR, MD 21014</b>                                                                                            |  |                                                                            |  | 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                     |  |                                                             |  | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                |  |
|                                               | 33. State Registrar                                                                                                                                                                                                                   |  |                                                                            |  | 34. State Registrar                                                                                                                                                                                                                                                                         |  |                                                             |  | 35. State Registrar                                                                                                                                                                                                                                                                                                                                                                                                          |  |






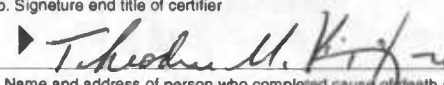
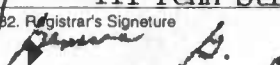
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State of Maryland / Department of Health and Mental Hygiene

00 23164

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                                                                                                                               |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Frederick William Stouffer</b>           |                                                                                                                                                               |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 07, 2000</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>1000 am</b>                          |                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Old Forge Road</b> |                                                                                                                                                               |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |                                                                                                                                                                                                  | 4c. County of Death<br><b>Washington</b>                    |                                                                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>219-14-7663</b>                                         |                                                                                                                                                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.           |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 10, 1923</b> |                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                             |                                                                                                                                                               | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                              | 10b. County<br><b>Washington</b>                           |                                                                                                                                                                                                  | 10c. City, Town or Location<br><b>Hagerstown</b>            |                                                                        |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                |                                                                            | 10e. Street and Number<br><b>411 East Irvin Avenue</b>                                                                                                                                       |                                                            | 10f. Zip Code<br><b>21742</b>                                                                                                                                                                    |                                                             | 10g. Citizen of What Country?<br><b>U. S. A.</b>                       |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943</b> |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |                                                             |                                                                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+) <b>-</b>                                                                                                                                                                                                                                                                                      |                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machanist</b>                                 |                                                                            | 16b. Kind of Business/Industry<br><b>Private Industry</b>                                                                                                                                    |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Frederick Stouffer</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |                                                                                                                                                               |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Thelma Mildred Bowers</b>                                                                                                            |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara L. Ridenour / sister</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                         |                                                                                                                                                               |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2015 Maplewood Dr. Hagerstown, MD 21742</b>                                              |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>                                                          |                                                                            | Date<br><b>7/11/00</b>                                                                                                                                                                       |                                                            | 20c. Location - City or Town, State<br><b>Hagerstown, MD</b>                                                                                                                                     |                                                             |                                                                        |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                              |                                                                                         |                                                                                                                                                               |                                                                            | 22. Name and Address of Facility<br><b>Rest Haven Funeral Chapel</b><br><b>1601 Pennsylvania Ave. Hagerstown, MD 21742</b>                                                                   |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Carbon Monoxide Intoxication</b><br>Due to (or as a consequence of):                                                               |                                                                                         | b. Due to (or as a consequence of):                                                                                                                           |                                                                            | c. Due to (or as a consequence of):                                                                                                                                                          |                                                            | d. Due to (or as a consequence of):                                                                                                                                                              |                                                             | Approximate Interval Between Onset and Death                           |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c. Carbon Monoxide Intoxication</b>                                                                                                                                                                                                                         |                                                                                         |                                                                                                                                                               |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                                                                                                                               |                                                                            |                                                                                                                                                                                              |                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                             |                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                                                                                                                               |                                                                            |                                                                                                                                                                                              |                                                            | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |                                                             |                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                                                                                                                               |                                                                            |                                                                                                                                                                                              |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                               |                                                             |                                                                        |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                         | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                                              |                                                                            | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>   |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                     |                                                                                         | 28a. Date of Injury (Month, Day, Year)<br><b>Found 7/7/00</b>                                                                                                 |                                                                            | 28b. Time of Injury<br><b>0800 AM</b>                                                                                                                                                        |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                             | 28d. Describe how injury occurred<br><b>Subject inhales into fumes</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>vehicle</b>                                                      |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Old Forge Road Hagerstown Maryland</b>                                                                    |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                         | 29b. Signature and title of certifier<br><br><b>Theodore M. King</b>       |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                       |                                                            | 29d. Date signed (Month, Day, Year)<br><b>July 08, 2000</b>                                                                                                                                      |                                                             |                                                                        |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                   |                                                                                         |                                                                                                                                                               |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                         | 32. Registrar's Signature<br><br><b>B. Sparks</b>                          |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                             |                                                                        |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23165

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN CLOPPER SINNISEN

2. Date of Death

Month  
JULYDay  
9Year  
2000

3. Time of Death

9:15 A.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

97 NORTH MAIN STREET

4b. City, Town, or Location of Death

KEEDYSVILLE

4c. County of Death

WASHINGTON

5. Social Security Number

215-18-1759

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 25, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

KEEDYSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

97 NORTH MAIN STREET

10f. Zip Code

21756

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

POST OFFICE

17. Father's Name (First, Middle, Last)

JOHN W. LONG SR.

18. Mother's Name (First, Middle, Maiden Surname)

FLOSSIE M. CLOPPER

19a. Informant's Name/Relationship (Type, Print)

NANCY L. GUYER/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 34, KEEDYSVILLE, MARYLAND 21756

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FAIRVIEW CEMETERY

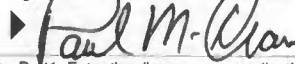
Date

7/12/00

20c. Location - City or Town, State

KEEDYSVILLE, MARYLAND

21. Signature of Funeral Service Licensee



Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. *probable cerebro-vascular accident*

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death*immediate*Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

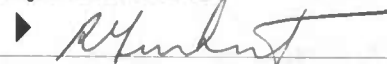
27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 32518

29d. Date signed (Month, Day, Year)

7.11.00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. R. Guedenet

100 Geeting Lane, Keedysville, Maryland 21756

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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within 24 hours after death.  
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23166

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>David Smith                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   | 2. Date of Death<br>Month Day Year<br>July 7, 2000                                                                                                                                                |                                                                                      | 3. Time of Death<br>2:35 A.M.                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Millennium Health & Rehabilitation Center                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   | 4b. City, Town, or Location of Death<br>Edgewater                                                                                                                                                 |                                                                                      | 4c. County of Death<br>Anne Arundel                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>579-01-4712                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                            |                                   | 7. Age (In yrs. last birthday)<br>86 Yrs.                                                                                                                                                         |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Apr. 8, 1914              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      | 9. Birthplace (State or Foreign Country)<br>Maryland             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10a. State<br>Maryland                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         | 10b. County<br>Calvert                                                                                                                                |                                   | 10c. City, Town or Location<br>Dunkirk                                                                                                                                                            |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>9650 Howes Road                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   | 10f. Zip Code<br>20754                                                                                                                                                                            |                                                                                      | 10g. Citizen of What Country?<br>USA                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                          |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Supervisor                                                                           |                                                                                      | 16b. Kind of Business/Industry<br>Food Services                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Maud Smith                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rosie Hicks                                                                                                                                  |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Norma Hutcheson/Niece                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3829 13th St. NW Washington, D.C. 20011                                                          |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Coopers UM Church Cem.                                                      |                                   | Date<br>7/14/00                                                                                                                                                                                   |                                                                                      | 20c. Location - City or Town, State<br>Dunkirk, MD               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>▶ <i>Blodge A. Sweet</i>                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   | 22. Name and Address of Facility<br>Sewell Funeral Home<br>1451 Dares Beach Rd. Prince Frederick, MD 20678                                                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <u>SEPSIS</u><br>Due to (or as a consequence of):<br>b. <u>PNEUMONIA</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____                                                                                                                                                                                |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  | 1 DAY<br>1 DAY.                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>ATHEROSCLEROTIC CARDIO VASCULAR DISEASE</u><br><u>DEMENTIA</u>                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                                       | 28b. Time of Injury<br>M          |                                                                                                                                                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                                       | 28d. Describe how injury occurred |                                                                                                                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 29b. Signature and title of certifier<br>▶ <i>Gyan C. Surana</i>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 29c. License number<br>D.50653    |                                                                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br>7-7-2000                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>GYAN C SURANA</u><br><u>5851 Deale Churchton Road Deale MD 20751</u>                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br>▶ <i>Benita B. Smith</i>                                                                                                                                                                                                                                                   |                                                                                                                                                       |                                   |                                                                                                                                                                                                   |                                                                                      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23167

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AUDREY

ROXANNE

SULLIVAN

2. Date of Death

Month Day Year  
July 08, 2000

3. Time of Death

00:50

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Pr. Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

579-03-5148

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
8/23/12

9. Birthplace (State or Foreign Country)

MN

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Chesapeake Beach

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3811 17th Street

10f. Zip Code

20732

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John H. Berndgen

18. Mother's Name (First, Middle, Maiden Surname)

Mary Dahlen

19a. Informant's Name/Relationship (Type, Print)

Nora Van Name/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13811 Eden Way, Chantilly, VA 20151

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

So. Memorial Gardens

Date

7/11/00 Dunkirk, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Raymond-Wood F.H., P.A.  
PO Box 430, Dunkirk, MD 20754

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute anterior MI, v fib

Due to (or as a consequence of):

b. CHF

Due to (or as a consequence of):

c. COPD

Due to (or as a consequence of):

d. asthma

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

MD 030842

29d. Date signed (Month, Day, Year)

July 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Demekas MD 100 Hospital Road Prince Frederick

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature



MD

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23168

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LINDA KATHLEEN THORPE

2. Date of Death

JULY 08 2000

3. Time of Death

06:10 AM

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

216 40 8270

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

57

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Aug. 1, 1942

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State MD 10b. County Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1417 Dicus Mile Rd

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

manager

16b. Kind of Business/Industry

retail-food

17. Father's Name (First, Middle, Last)

Hillery Issac Bowen

18. Mother's Name (First, Middle, Maiden Surname)

Kathleen Virginia Seggie

19a. Informant's Name/Relationship (Type, Print)

Kenneth E. Bowen (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 588, Solomons, MD 20688

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium or other place)

Solomons UMC Cemetery

Date

7-12-00

20c. Location - City or Town, State

Solomons, MD

21. Signature of Funeral Service Licensee

B Rausch

22. Name and Address of Facility

Rausch Funeral Home, 4405 Broomes Island Road  
Port Republic, MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Candida Esophagitis

Due to (or as a consequence of):

c. Multiorganism Septicemia

Due to (or as a consequence of):

d. Chronically immunosuppressed

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Steroid Dependent Rheumatoid Arthritis

Malignant Hypertension

Rheumatoid Interstitial lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Jani

29c. License number

D45092

29d. Date signed (Month, Day, Year)

7/8/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PARUL JANI, MD 100 HOSPITAL RD PRINCE FREDERICK, MD

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

Beverly G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23169

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                 |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>LILLIAN Florence VENNERI</b>                                                                                                                                                                     |                                                                                                                             | 2. Date of Death<br>Month <b>JULY</b> Day <b>6</b> Year <b>2000</b>                                                                                   |                                                        | 3. Time of Death<br><b>9:15 am</b>                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>                                                                                                                                              |                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>                                                                                       |                                                        | 4c. County of Death<br><b>Calvert</b>                                                                                                                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><b>295-20-2977</b>                                                                                                                                                                                                 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                              | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                                                                                                      | If Under 1 Year<br>Months Days                         | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>March 22, 1912</b>                                                                                                                                                                                    |                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Italy</b>                                                                                              |                                                        |                                                                                                                                                                                                   |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br><b>MD</b>                                                                                                                                                                                                                         |                                                                                                                             | 10b. County<br><b>Anne Arundel</b>                                                                                                                    |                                                        | 10c. City, Town or Location<br><b>Lothian</b>                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                              |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br><b>322 Ella Drive</b>                                                                                                                                                                                                 |                                                                                                                             | 10f. Zip Code<br><b>20711</b>                                                                                                                         |                                                        | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                          |                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                         |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)                                                                                                                     |                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |                                                        | 16b. Kind of Business/Industry<br><b>Home</b>                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br><b>Steven Gialucci</b>                                                                                                                                                                               |                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Unknown</b>                                                                                     |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph G. Venneri, Jr. (Son)</b>                                                                                                                                                         |                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 509 Lothian, MD 20711</b>                |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lee Crematory</b>                                                        |                                                        | Date<br><b>July 7, 2000</b>                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20c. Location - City or Town, State<br><b>Clinton, MD</b>                                                                                                                                                                                       |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                 | 22. Name and Address of Facility<br><b>Lee Funeral Home Calvert, P.A.<br/>8125 Southern Maryland Blvd. Owings, MD 20736</b> |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |                                                                                                                             |                                                                                                                                                       |                                                        | Approximate Interval Between Onset and Death                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):                                                                                                       |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. ATRIAL FIBRILLATION</b><br>Due to (or as a consequence of):                 |                                                                                                                             |                                                                                                                                                       |                                                        | <b>1 WK</b>                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due to (or as a consequence of):                                                                                                                                                                                                                |                                                                                                                             |                                                                                                                                                       |                                                        | <b>20 YRS</b>                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due to (or as a consequence of):                                                                                                                                                                                                                |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due to (or as a consequence of):                                                                                                                                                                                                                |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                          |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                        |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                       |                                                                                                                             |                                                                                                                                                       |                                                        | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                      |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                     |                                                                                                                                                                                                                                                 |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                   |                                                                                                                                                                                                                                                 | 28a. Date of injury (Month, Day, Year)                                                                                      |                                                                                                                                                       | 28b. Time of injury<br><b>M</b>                        |                                                                                                                                                                                                   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                 | 28d. Describe how injury occurred                                                                                           |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                 |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 | 29c. License number<br><b>029657</b>                                                                                        |                                                                                                                                                       | 29d. Date signed (Month, Day, Year)<br><b>7/6/2000</b> |                                                                                                                                                                                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. CHARLES JUDGE, MD., PRINCE FREDERICK, MD 20657</b>                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                 |                                                                                                                             |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 07 2000</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br>                                                                                               |                                                                                                                                                       |                                                        |                                                                                                                                                                                                   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23170

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John V. Walker, Jr.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <b>July</b> Day <b>7</b> Year <b>2000</b>                                                                                                                           |  | 3. Time of Death<br><b>2:10pm</b>                                                                                                                                                                           |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1757 Gablehammer Road</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>                                                                                                                                    |  | 4c. County of Death<br><b>Carroll</b>                                                                                                                                                                       |  |
| 5. Social Security Number<br><b>212-42-8781</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.                                                                                                                                              |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 29 1944</b>                                                                                                                                                   |  |
| 9. Birthplace (State or Foreign Country)<br><b>NC</b>                                                                                                                                                                                                                                                                                                                                                                        |  | Usual Residence of Decedent                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. County<br><b>Carroll</b>                                                                                                                                                                                                                                                               |  | 10c. City, Town or Location<br><b>Westminster</b>                                                                                                                                             |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                              |  |
| 10e. Street and Number<br><b>1757 Gablehammer Road</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>21158</b>                                                                                                                                                                 |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1964</b><br><b>1968</b>                                                                                                                |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Agent</b>                                                                      |  | 16b. Kind of Business/Industry<br><b>Real Estate</b>                                                                                                                                                        |  |
| 17. Father's Name (First, Middle, Last)<br><b>John V. Walker, Sr.</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruby Turner</b>                                                                                                                       |  |                                                                                                                                                                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Janet Walker/wife</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1757 Gablehammer Road Westminster, MD 21158</b>                                           |  |                                                                                                                                                                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Johns (Leisters)</b>                                                                                                                                                                                       |  | Date<br><b>7/10</b>                                                                                                                                                                           |  | 20c. Location - City or Town, State<br><b>Westminster, MD</b>                                                                                                                                               |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>Pritts Funeral Home and Chapel</b><br><b>412 Washington Rd Westminster, MD 21157</b>                                                                   |  |                                                                                                                                                                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>RENAL CA</b><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  | Approximate Interval Between Onset and Death<br><b>8 mos</b>                                                                                                                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                          |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                      |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                 |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                                                                                                                                                                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>DS5398</b>                                                                                                                                                          |  | 29d. Date signed (Month, Day, Year)<br><b>7-10-00</b>                                                                                                                                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Flavio Kruser, M.D. 224 Washington Heights, Westminster, MD 21157</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23171

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Earl Ellsworth Weaver, Jr.

2. Date of Death

Month Day Year  
July 6 2000

3. Time of Death

7:10 am

4a. Facility Name (If not institution, give street and number)

13 West Sunset Avenue

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

218-24-1608

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 12, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

13 West Sunset Avenue

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Boat Parts Distributor

17. Father's Name (First, Middle, Last)

Earl Ellsworth Weaver, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Edna Obitts

19a. Informant's Name/Relationship (Type, Print)

Emma Weaver/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 West Sunset Avenue Williamsport, MD 21795

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenlawn Memorial Park

Date

7-8-00

20c. Location - City or Town, State

Williamsport, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home, P.A.

425 S. Conococheague St. Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

b. Chronic Obstructive pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 1/2 yrs.

10 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide  
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahden Iqbal 12821 Oakhill Ave Hagood 21742

31. Date filed (Month, Day, Year)

JUL 07 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23172

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE AMISTAD WRIGHT

2. Date of Death

JULY 09 2000

3. Time of Death

08:32 AM

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

577 14 9673

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)  
Oct 30 1913

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Calvert

10c. City, Town or Location

Port Republic

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3620 Pine Tree Road

10f. Zip Code

20676

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

delivery truck

16b. Kind of Business/Industry

Schmidts Baking Co.

17. Father's Name (First, Middle, Last)

George L. Wright

18. Mother's Name (First, Middle, Maiden Surname)

Lotta P. Roseway

19a. Informant's Name/Relationship (Type, Print)

Ronald C Schreiber- stepson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

925 Western Shores Blvd Port Republic MD 20676

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Funeral Service Alexandria Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

B. Rausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Methicillin Resistance Staphylococcus Aureus

1 WEEK

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident.

Atherosclerotic Cardio Vascular disease

Colon Cancer.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Beyanched Enana.

29c. License number

D 50653

29d. Date signed (Month, Day, Year)

7-9-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5851 Dealechworth Road

GYAN - C. SURANA MD

Deale, MD 20751

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

Beyanched Enana.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23173

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br>Robert Leslie Armiger                 |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br>JULY 20, 2000 |                                                                    |                                                              |                                                                                                                                                                                                             | 3. Time of Death<br>7:56 P.M.                        |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br>HARBOR HOSPITAL |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br>BALTIMORE   |                                                                    |                                                              |                                                                                                                                                                                                             | 4c. County of Death                                  |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5. Social Security Number<br>214-66-3518                                          |                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>46                |                                                                    | 8. Date of Birth (Month, Day, Year)<br>1954<br>July 14, 2000 |                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br>Maryland |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Usual Residence of Decedent                                                       |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   | 10b. County<br>Anne Arundel                                                                                                                       |                                                                            | 10c. City, Town or Location<br>Linthicum                                                                                                                                                                                                                                                 |                                                     |                                                                    |                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                              |                                                      |                                              |  |
| 10e. Street and Number<br>302 Camp Meade Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                   |                                                                                                                                                   |                                                                            | 10f. Zip Code<br>21090                                                                                                                                                                                                                                                                   |                                                     |                                                                    |                                                              | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                                                                     |                                                      |                                              |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                            |                                                     |                                                                    |                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                            |                                                      |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                                                                                                                   |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Maintenance                                                                                                                                                                 |                                                     |                                                                    |                                                              | 16b. Kind of Business/Industry<br>Northrop and Grumman                                                                                                                                                      |                                                      |                                              |  |
| 17. Father's Name (First, Middle, Last)<br>William L. Armiger                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                   |                                                                                                                                                   |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nancy L. Truitt                                                                                                                                                                                                                     |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Ronald W. Armiger                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                   |                                                                                                                                                   |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>808 Meadowbrook Road, Glen Burnie, MD 21061                                                                                                                                             |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                                                                                                                   |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery                                                                                                                                                                                            |                                                     | 20c. Location - City or Town, State<br>7-26-2000 Brooklyn Park, MD |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br>Singleton Funeral Home P.A.<br>Second Ave. S.W. Glen Burnie, MD 21061                                                                                                                                                                                |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>OCCLUSIVE PULMONARY THROMBOEMBOLI<br>a. Due to (or as a consequence of):<br>DEEP VEIN THROMBOSIS<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                   |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |                                                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                      |                                              |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                   |                                                                                                                                                   |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                              |                                                                                   |                                                                                                                                                   |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                   |                                                     | 28b. Time of Injury<br>M                                           |                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                 |                                                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                                                                                                                   |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                        |                                                     |                                                                    |                                                              | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                |                                                      |                                              |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                  |                                                                                   |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |                                                                                                                                                   |                                                                            | 29c. License number<br>O.C.M.E.                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              | 29d. Date signed (Month, Day, Year)<br>JULY 21, 2000                                                                                                                                                        |                                                      |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   | 31. Date filed (Month, Day, Year)<br>JUL 24 2000                                                                                                  |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                         |                                                     |                                                                    |                                                              |                                                                                                                                                                                                             |                                                      |                                              |  |

113

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23174

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

3

State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                   |                                                                                                                                                                                                  |                                                                         |                                                                                                |  |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JAMIE ANDERSON</b>                                                                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br><b>JULY 20, 2000</b>                                                                                                                                                                                                                                  |                                                          | 3. Time of Death<br><b>9:50 P.M.</b>                                                                                                                                                         |                                   |                                                                                                                                                                                                  |                                                                         |                                                                                                |  |                                                             |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b> |                                                                                                                                                                                              | 4c. County of Death<br><b>N/A</b> |                                                                                                                                                                                                  |                                                                         |                                                                                                |  |                                                             |  |
| 5. Social Security Number<br><b>220-04-4209</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |                                                          | 7. Age (In yrs. last birthday)<br><b>16</b> Yrs.                                                                                                                                             |                                   | 8. Date of Birth (Month, Day, Year)<br><b>11-24-1983</b>                                                                                                                                         |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                          |  |                                                             |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. County<br><b>N/A</b>                                                                                                                                                                                                                                                                   |                                                          | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                              |                                   |                                                                                                                                                                                                  |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |                                                             |  |
| 10e. Street and Number<br><b>4610 PARK HEIGHTS AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |                                                          | 10f. Zip Code<br><b>21215</b>                                                                                                                                                                |                                   | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                                                         |                                                                                                |  |                                                             |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                   |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |                                                                                                |  |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>STUDENT</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SCHOOL</b>                                                                   |                                   |                                                                                                                                                                                                  | 16b. Kind of Business/Industry                                          |                                                                                                |  |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES ANDERSON, SR.</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |                                                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>PAULETTE HOLLAND</b>                                                                                                                 |                                   |                                                                                                                                                                                                  |                                                                         |                                                                                                |  |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PAULETTE HOLLAND /MOTHER</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |                                                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4610 PARK HGHTS AVENUE, BALTO., MD. 21215</b>                                            |                                   |                                                                                                                                                                                                  |                                                                         |                                                                                                |  |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS</b>                                                                                                                                                                                                    |                                                          | Date<br><b>7/25/2000</b>                                                                                                                                                                     |                                   | 20c. Location - City or Town, State<br><b>BALTO., MD.</b>                                                                                                                                        |                                                                         |                                                                                                |  |                                                             |  |
| 21. Signature of Funeral Service Licensee<br><i>James A. Morton</i>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |                                                          | 22. Name and Address of Facility<br><b>JAMES A. MORTON &amp; SONS F.H., INC<br/>1701 LAURENS ST. BALTO., MD. 21217</b>                                                                       |                                   |                                                                                                                                                                                                  |                                                                         |                                                                                                |  |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Multiple Gunshot Wounds</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):                               |  |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                   | Approximate Interval Between Onset and Death                                                                                                                                                     |                                                                         |                                                                                                |  |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                         |                                                                                                |  |                                                             |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                               |                                                                         |                                                                                                |  |                                                             |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                          |                                                                                                                                                                                              |                                   |                                                                                                                                                                                                  |                                                                         |                                                                                                |  |                                                             |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. Date of Injury (Month, Day, Year)<br><b>7/20/00</b>                                                                                                                                                                                                                                    |                                                          | 28b. Time of injury<br><b>2131</b> M                                                                                                                                                         |                                   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                                         | 28d. Describe how injury occurred<br><b>Subject Shot</b>                                       |  |                                                             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Street (Found)</b>                                                                                                                                                                                                                                                                                                           |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3505 Woodland Ave<br/>Baltimore, Md.</b>                                                                                                                                                                 |                                                          |                                                                                                                                                                                              |                                   |                                                                                                                                                                                                  |                                                                         |                                                                                                |  |                                                             |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                   | 29b. Signature and title of certifier<br><i>Joseph Pestaner, MD.</i>                                                                                                                             |                                                                         | 29c. License number<br><b>O.C.M.E.</b>                                                         |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 21, 2000</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Pestaner 111 Penn St Balto, MD 21201</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                   | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                          |                                                                         | 32. Registrar's Signature<br><i>Sparks</i>                                                     |  |                                                             |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23175

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Tom Bert

2. Date of Death

Month Day Year  
July 20 2000

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

5. Social Security Number

244-16-7746

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 3, 1920

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1806 East 31st Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Bethlehem Steel Corp.

17. Father's Name (First, Middle, Last)

Henry Bert

18. Mother's Name (First, Middle, Maiden Surname)

Cannary Brown

19a. Informant's Name/Relationship (Type, Print) wife

Marion O. Bert

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1806 East 31st Street Baltimore, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Memorial Garden

Date

7/25

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.  
2501 Gwynns Falls Pkwy  
Baltimore, MD 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adult Respiratory Distress Syndrome

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Prostate Carcinoma

Due to (or as a consequence of):

10 yr

c. Metastasis to liver

Due to (or as a consequence of):

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wael Samara, M.D.

29c. License number

D52016

29d. Date signed (Month, Day, Year)

July 1, 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wael Samara, M.D., Union Memorial Hosp

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Wael Samara

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

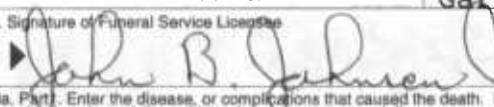

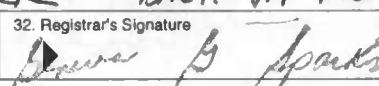
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #1 PER MD G785 7-24-00 WR **Certificate of Death** 00 23176

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM BROWN SR.</b>                                                |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               | 2. Date of Death<br>Month <b>07</b> Day <b>05</b> Year <b>2000</b> |                                                                                  | 3. Time of Death<br><b>10:00 A.M.</b>                                                          |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>BALTIMORE VETERANS ADMINISTRATION HOSPITAL</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>           |                                                                                  | 4c. County of Death<br><b>—</b>                                                                |                                                                                                                                                                                                  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>216-12-0454</b>                                                                     |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                                                                              | If Under 1 Year<br>Months <b>3</b> Days                            | If Under 24 Hrs.<br>Hours Min.                                                   | 8. Date of Birth (Month, Day, Year)<br><b>03 22 20</b>                                         | 9. Birthplace (State or Foreign Country)<br><b>M.D.</b>                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                     | 10b. County<br><b>NA</b>                                                                                                                                                                                                                                                                    |                                                                            | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                               |                                                                    |                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>3122 Thornfield Road</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            | 10f. Zip Code<br><b>21207</b>                                                                                                                                                                 |                                                                    | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |                                                                                                |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                    |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>na</b>                                                                                                                                                                                                                                                                               |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>                                                                   |                                                                    |                                                                                  | 16b. Kind of Business/Industry<br><b>Westside Stables</b>                                      |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>John Wesley Brown</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Henrietta Scribner</b>                                                                                                                |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Brown Jr.-Son</b>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3122 Thornfield Road, Baltimore Md 21207</b>                                              |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet 7/11/00 Owings Mills, Md</b>                                                                                                                                                               |                                                                            |                                                                                                                                                                                               | 20c. Location - City or Town, State                                |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                           |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>March F/H West<br/>4300 Wabash Ave, Baltimore Md 21215</b>                                                                                             |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PNEUMONIA</b>                                                                                                                                                                                             |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                | Approximate Interval Between Onset and Death                                                                                                                                                     |
| Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                    |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| c. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| d. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                     | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                             |                                                                                                                     | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                            | 28b. Time of Injury<br>M                                                                                                                                                                      |                                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                                                                                                                                                                |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                     | 29b. Signature and title of certifier<br>                                                                                                                                                                |                                                                            |                                                                                                                                                                                               | 29c. License number<br><b>D0054861</b>                             |                                                                                  | 29d. Date signed (Month, Day, Year)<br><b>07/05/2000</b>                                       |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT CORDER BACT. VA MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                      |                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                     | 32. Registrar's Signature<br>                                                                                                                                                                            |                                                                            |                                                                                                                                                                                               |                                                                    |                                                                                  |                                                                                                |                                                                                                                                                                                                  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



E.K.S

BRANCH BROWN JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23177

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>BRANCHE BROWN JR                        |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br>JULY 15, 2000                                                                                                                                              |                                                                                                                                    |                                |                                                                                                                    | 3. Time of Death<br>0019 AM                                      |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>916 STROLL STREET |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br>BALTIMORE                                                                                                                                                |                                                                                                                                    |                                |                                                                                                                    | 4c. County of Death                                              |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>214-86-3718                                            |             | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>24 Yrs.                                                                                                                                                        |                                                                                                                                    | If Under 1 Year<br>Months Days |                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br>8-1-1975                  |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>MD |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                         |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                     | 10b. County |                                                                                                                                                       | 10c. City, Town or Location<br>BALTIMORE                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |                                                |                                                                                                                                                        |  |
| 10e. Street and Number<br>4133 HYDEN CT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |             |                                                                                                                                                       | 10f. Zip Code<br>21225                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                  |                                                                                                                                    |                                | 10g. Citizen of What Country?<br>U.S.A.                                                                            |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                     |             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                    |                                |                                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |             |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>UNKNOWN                                                                                                                                                                                             |                                                                                                                                                                                                  |                                                                                                                                    |                                | 16b. Kind of Business/Industry                                                                                     |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 17. Father's Name (First, Middle, Last)<br>BRANCHE BROWN SR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>CORA WOOD                                                                     |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>CORA WOOD (MOTHER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4133 HYDEN CT. BALTIMORE MD 21225 |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                               |                                                                                     |             |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MT. ZION CEMETERY 7-22-2000 BALTO. CO. MD                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                                                    |                                | 20c. Location - City or Town, State                                                                                |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 21. Signature of Funeral Service Licensee<br>EUGENE WALKER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  | 22. Name and Address of Facility<br>ESTEP BROS. FUNERAL SERVICE<br>1300 EUTAW PLACE BALTO. MD 21217                                |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>MULTIPLE GUNSHOT WOUNDS<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                | Approximate Interval Between Onset and Death                                                                                                           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                |                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     |             |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                     |                                                                                     |             |                                                                                                                                                       | 28a. Date of Injury (Month, Day, Year)<br>7/15/00                                                                                                                                                                                                                                                                |                                                                                                                                                                                                  | 28b. Time of Injury (Hour, Minute)<br>12:23 A M                                                                                    |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                    |                                                                  | 28d. Describe how injury occurred<br>SUBJECT SHOT                                                                                                                                                        |                                                |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     |             |                                                                                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>STREET                                                                                                                                                                                                                 |                                                                                                                                                                                                  |                                                                                                                                    |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>916 STROLL STREET<br>BALTIMORE, MD |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                 |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 29b. Signature and title of certifier<br>J.M. [Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  | 29c. License number<br>O.C.M.E                                                                                                     |                                | 29d. Date signed (Month, Day, Year)<br>JULY 15, 2000                                                               |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JACK M. TIMM, M.D. 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     |             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                     |             |                                                                                                                                                       | 32. Registrar's Signature<br>[Signature]                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                    |                                |                                                                                                                    |                                                                  |                                                                                                                                                                                                          |                                                |                                                                                                                                                        |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Wt. 1/2

20

1/2

20

1/2

1/2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23178

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD F. BLANEY

2. Date of Death

Month

Day

Year

July 14 2000

3. Time of Death

1415

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

212-07-6226

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb 6, 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

31936 Sutherland Drive

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

sales

16b. Kind of Business/Industry

oil

17. Father's Name (First, Middle, Last)

Edward F. Blaney

18. Mother's Name (First, Middle, Maiden Surname)

Emily F. Franklin

19a. Informant's Name/Relationship (Type, Print)

Gertrude Blaney/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31936 Sutherland Drive Salisbury, MD 21804

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Lymphoma

Due to (or as a consequence of):

7 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Volume Depletion

Renal Failure

Hyoglycemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James E. MARTIN, M.D., 145 E. Carroll St., Salisbury, MD.

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Dennis P. Sparks

State Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95





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State of Maryland / Department of Health and Mental Hygiene

00 23179

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>SUSAN LEVY BODENHEIMER</b>                            |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>JULY 18 2000</b> |                                                                                             | 3. Time of Death<br><b>7:32pm</b>                                                              |                                                       |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b> |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                                                             | 4c. County of Death<br><b>N/A</b>                                                              |                                                       |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>212-20-9219</b>                                                      |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                            | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                                                                                                                                             |                                                           | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 26, 1923</b>                                 |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                                          |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                      | 10b. County<br><b>N/A</b> |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                       |                                                                                                                                                                                                  |  |
| 10e. Street and Number<br><b>7218 PARK HEIGHTS AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            | 10f. Zip Code<br><b>21208</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                      |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |                                                       |                                                                                                                                                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ARTIST</b> |                                                                                                                                                                                              |                                                           | 16b. Kind of Business/Industry<br><b>ART</b>                                                |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>LESTER S. LEVY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELINOR KOHN</b>                                                                                                                      |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JANET FISHBEIN / DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 MELISA COURT - OWINGS MILLS, MD 21117</b>                                              |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHEVRA AHAVAS CHESD</b>                                                                                                                                                                                        |                                                                                                                            | Date<br><b>7/21/00</b>                                                                                                                                                                       |                                                           | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD</b>                              |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                                                                  |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                                                |                                                       | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypothyroidism</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                                                |                                                       | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                           |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      |                           | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      |                           | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                     |                                                                                                                                                                                                  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                       |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br> <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            | 29c. License number<br><b>RES 000</b>                                                                                                                                                        |                                                           | 29d. Date signed (Month, Day, Year)<br><b>JULY 18 2000</b>                                  |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Sinai Hospital of Baltimore 2401 W. Belvedere Avenue Baltimore, MD 21215-5271</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                      |                           | 32. Registrar's Signature<br>                                                                                                                                                                            |                                                                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                                                |                                                       |                                                                                                                                                                                                  |  |

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State of Maryland / Department of Health and Mental Hygiene

00 23180

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>SHIRLEY BECK</b>                                  |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>JULY 20, 2000</b>                                                                                            |                                                                                                                                                                                                  | 3. Time of Death<br><b>4:56 AM</b>             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>PIKESVILLE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                              |                                                                                                                                                                                                  | 4c. County of Death<br><b>BALTIMORE</b>        |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>217-03-9327</b>                                                  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.                                                                                                      | If Under 1 Year<br>Months Days                                                                                                                                                                   | If Under 24 Hrs.<br>Hours Min.                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. Date of Birth (Month, Day, Year)<br><b>OCT. 11, 1916</b>                                      |                                                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                 |                                                                                                                                                                                                  |                                                |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  | 10b. County<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                                  |                                                |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 10e. Street and Number<br><b>16 OLD COURT ROAD #701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br><b>21208</b>                                                                                                                         |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                                                                                                                                                                           |                                                                                                                                                       | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                                                                                                                                |                                                |
| 17. Father's Name (First, Middle, Last)<br><b>MORRIS COHEN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                                                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA LAKERNIK</b>                                                                             |                                                                                                                                                                                                  |                                                |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOAN BITAR / DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                                                                                                                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4426 CREEKBEND DRIVE - HOUSTON, TX 77035-5012</b> |                                                                                                                                                                                                  |                                                |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CIRCLE BOBROISKER BENEFICIAL</b>                                                                                                                                                                                           |                                                                                                                                                       | 20c. Location - City or Town, State<br><b>7/20/00 ROSEDALE, MD</b>                                                                                                                               |                                                |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><b>ASPIRATION PNEUMONIA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>DEHYDRATION</b><br><b>LIVER CIRRHOSIS</b><br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DEHYDRATION</b><br><b>LIVER CIRRHOSIS</b> |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |                                                |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                                                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                           |                                                |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  | 29c. License number<br><b>D-22609</b>                                                                                                                                                                                                                                                                   |                                                                                                                                                       | 29d. Date signed (Month, Day, Year)<br><b>JULY 20, 2000</b>                                                                                                                                      |                                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RUBEN REIDER M.D. 7445 FURNACE BRANCH RD GLENBURNIE MD 21060</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  | 32. Registrar's Signature<br>                                                                                                                                                                                        |                                                                                                                                                       |                                                                                                                                                                                                  |                                                |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23181

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joe Lee Connor, Jr.

2. Date of Death

Month Day Year  
July 9, 2000

3. Time of Death

11:17am

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

216-42-0850

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 12, 1944

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5511 Wesley Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Postal Worker

16b. Kind of Business/Industry

US Postal Service

17. Father's Name (First, Middle, Last)

Joe Lee Connor, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Alice May

19a. Informant's Name/Relationship (Type, Print)

Denise Connor wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5511 Wesley Avenue Baltimore, Md. 21207

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forrest Veterans July 17 Owings Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Amest B. Ferry, Jr.

22. Name and Address of Facility

Nutter Funeral Homes, Inc.  
2501 Gwynns Falls PKWY Baltimore, Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Atherosclerotic vessel disease

Due to (or as a consequence of):

Diabetes

Due to (or as a consequence of):

Hypertension

Due to (or as a consequence of):

renal insufficiency

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

No myocardial infarction

history of stroke

gastrointestinal bleed.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural ☐ Pending investigation  
2 ☐ Accident ☐ Could not be determined  
3 ☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M. Burnett

29c. License number

D53326

29d. Date signed (Month, Day, Year)

7/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marisa Burnette Kaiser Remanovich 7141 Security Blvd

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

2040 0000 11 11 11

2000 0000 11 11 11

2000 0000 11 11 11

2000 0000 11 11 11



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23182

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Edward Carroll

2. Date of Death

Month  
JULYDay  
11Year  
2000

3. Time of Death

0908

4a. Facility Name (If not institution, give street and number)

Union Memorial

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-50-9395

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MARCH 13, 1948

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1924 Fredericks Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CONSTRUCTION

16b. Kind of Business/Industry

BUILDING

17. Father's Name (First, Middle, Last)

Samuel Bright

18. Mother's Name (First, Middle, Maiden Surname)

Mable Carroll

19a. Informant's Name/Relationship (Type, Print)

CATHERINE CARROLL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5515 HARPERS FARM Rd. Columbia Md. 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

7-20-00 Catonsville, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gay P. March Funeral Home PA.  
8740 Frederick Road Baltimore, MD. 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Profound bradycardia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

60 min

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. infective endocarditis with nodal involvement 10 days

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acquired Immune Deficiency Syndrome

Congestive Heart Failure

Deep Vein Thrombosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

JULY 11 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOROTHY JACKSON UNION MEMORIAL HOSPITAL

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



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State of Maryland / Department of Health and Mental Hygiene

00 23183

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br><b>MIRIAM CLAYMAN</b>                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                | 2. Date of Death<br>Month Day Year<br><b>JULY 18 2000</b>                                                                                                                                        |                                                                                      |                                                             |                                                                                                    | 3. Time of Death<br><b>12:45PM</b>                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4a. Facility Name (If not institution, give street and number)<br><b>3737 CLARKS LANE APT. 204</b> |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                         |                                                                                      |                                                             |                                                                                                    | 4c. County of Death<br><b>N/A</b>                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br><b>217-46-1607</b>                                                    |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.                                                                                                                                                 |                                                                                      | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 31, 1905</b> |                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Usual Residence of Decedent                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    | 10b. County<br><b>N/A</b>                                                                                                                                                                                                                                                                               |                                                                                                                                                       | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                       |  |
| 10e. Street and Number<br><b>3737 CLARKS LANE #204</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 10f. Zip Code<br><b>21215</b>                                                                                                                  |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |                                                             |                                                                                                    |                                                       |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |                                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>                  |                                                                                                                                                                                                  |                                                                                      | 16b. Kind of Business/Industry<br><b>OWN HOME</b>           |                                                                                                    |                                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>ABRAHAM KRAMER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE FINE</b>                                                                         |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JANET POLLEKOFF / DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 POMONA WEST #9 - BALTIMORE, MD 21208</b> |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                    |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH TFILOH CEMETERY</b>                                                 |                                                                                                                                                |                                                                                                                                                                                                  | 20c. Date<br><b>7/20/00</b>                                                          |                                                             | 20d. Location - City or Town, State<br><b>WOODLAWN, MD</b>                                         |                                                       |  |
| 21. Signature of Funeral Service Licensee<br><i>Butler H. Levenson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 22. Name and Address of Facility<br><b>SOL LEVINSOHN &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                   |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive heart Failure</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Cmo</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Thrombosis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                      |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                                                |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                             | 28d. Describe how injury occurred                                                                  |                                                       |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                             |                                                                                                    |                                                       |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                        |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 29b. Signature and title of certifier<br><i>Samuel D. Benesh MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 29c. License number<br><b>016941</b>                                                                                                           |                                                                                                                                                                                                  |                                                                                      | 29d. Date signed (Month, Day, Year)<br><b>7/18/00</b>       |                                                                                                    |                                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Samuel D. Benesh 21 Crossroads Dr - Owings Mills, md 21117</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 32. Registrar's Signature<br><i>Sparks</i>                                                                                                     |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                                                    |                                                       |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 23184

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard J. Doneski, Jr.

2. Date of Death

Month Day Year  
July 22, 2000

3. Time of Death

2:00 p.m.

4a. Facility Name (If not institution, give street and number)

Forest Haven Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-36-2074

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 16, 1935

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Cherry Hill Ct.

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Music Teacher

16b. Kind of Business/Industry

Private lessons

17. Father's Name (First, Middle, Last)

Leonard J. Doneski, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Cecilia Loetz

19a. Informant's Name/Relationship (Type, Print)

Frances Nelson - Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 Greenwood Apt. 3A Lithicum, Md. 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

July 27, 2000

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

*Justin R. J. [Signature]*

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd. Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a. Due to (or as a consequence of):

PNEUMONIA

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Latane Lakhan*

29c. License number

D28595

29d. Date signed (Month, Day, Year)

7/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALD MD 21208

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23185

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lorraine Droyd

2. Date of Death

July 20, 2000

3. Time of Death

6:40 pm

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-30-5978

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 21, 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2325 ESSEX STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

FRANK CUSTER

18. Mother's Name (First, Middle, Maiden Surname)

ANNA ADAMS

19a. Informant's Name/Relationship (Type, Print)

FRANK S. DROYD/ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3206 NORTH POINT ROAD, DUNDALK, MARYLAND 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREENMOUNT CEMETERY

Date

7/22/00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME  
1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive heart failure

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure, Respiratory failure, sepsis, Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37790

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nevins W Todd 301 St Paul Place Baltimore 21202

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 26 per phys. G785 7/24/00 yg

## Certificate of Death

Reg. No.

00 23186

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>GERTRUDE B. EPPLEY</b>                |                                                                                                                                                                                                                                                                                                                               | 2. Date of Death<br>Month Day Year<br><b>JULY 13, 2000</b>  |                                                                                                                                                         | 3. Time of Death<br><b>3:10 PM</b>         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>HEART HOMES</b> |                                                                                                                                                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>LINTHICUM</b>    |                                                                                                                                                         | 4c. County of Death<br><b>ANNE ARUNDEL</b> |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>216-44-5875</b>                                      | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                    | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.            | If Under 1 Year<br>Months Days                                                                                                                          | If Under 24 Hrs.<br>Hours Min.             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 14, 1910</b>                          |                                                                                                                                                                                                                                                                                                                               | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |                                                                                                                                                         |                                            |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
| 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      | 10b. County<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                                                                            |                                                             | 10c. City, Town or Location<br><b>GLEN BURNIE</b>                                                                                                       |                                            |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                      | 10e. Street and Number<br><b>102 CRAIN HIGHWAY, APT. 881</b>                                                                                                                                                                                                                                                                  |                                                             | 10f. Zip Code<br><b>21061</b>                                                                                                                           |                                            |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                      | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                |                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:       |                                            |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                       |                                                             | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b> |                                            |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                                                                                                                                                                                                                                                             |                                                             | 17. Father's Name (First, Middle, Last)<br><b>CHARLES BURKOWSKA</b>                                                                                     |                                            |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET KRONER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      | 19a. Informant's Name/Relationship (Type, Print)<br><b>JEAN CLARKE (DAUGHTER)</b>                                                                                                                                                                                                                                             |                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>211 OONOGA WAY, LOUDON, TN. 37774</b>               |                                            |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>                                                                                                                                                                                                                     |                                                             | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD.</b>                                                                                          |                                            |
| 21. Signature of Funeral Service Licensee<br> <b>Mooz64</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                                                                                                                                                                                                    |                                                             |                                                                                                                                                         |                                            |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Bladder Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>assisted Living</b> |                                                             |                                                                                                                                                         |                                            |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                         |                                                             | 28b. Time of Injury<br><b>M</b>                                                                                                                         |                                            |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                             |                                                             | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                            |                                            |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      | 29c. License number<br><b>D34109</b>                                                                                                                                                                                                                                                                                          |                                                             | 29d. Date signed (Month, Day, Year)<br><b>7/14/00</b>                                                                                                   |                                            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Sylus 1100 Crain Hwy S Glen Burnie Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                                                                                         |                                            |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                                                              |                                                             |                                                                                                                                                         |                                            |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23187

OWEN

FAULKNER

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                        |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>OWEN Seclenton FAULKNER</b>              |                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br><b>JULY 21, 2000</b> |                                                                                                        | 3. Time of Death<br><b>8:45 P.M.</b>                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not Institution, give street and number)<br><b>4703 POST ROAD</b> |                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                                                                                        | 4c. County of Death<br><b>none</b>                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>231-36-6776</b>                                         |                                                                                                                                                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br><b>67</b>                |                                                                                                        | 8. Date of Birth (Month, Day, Year)<br><b>June 28, 1933</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                             |                                                                                                                                                                       | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                                                                                                                          | 10b. County<br><b>none</b>                                 |                                                                                                        | 10c. City, Town or Location<br><b>Baltimore</b>             |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         | 10e. Street and Number<br><b>4703 Post Road</b>                                                                                                                       |                                                                            | 10f. Zip Code<br><b>21215</b>                                                                                                                                                                                                                                                                            |                                                            | 10g. Citizen of What Country?<br><b>USA</b>                                                            |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>1951-1955</b> |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                             |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>AFRICAN AMERICAN</b>                  |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>steel worker</b>                                      |                                                                            | 16b. Kind of Business/Industry<br><b>beth steel</b>                                                                                                                                                                                                                                                      |                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>College (1-4 or 5+)<br><b>2 yrs</b> |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |                                                                                                                                                                       |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lelia Faulkner</b>                                                                                                                                                                                                                               |                                                            |                                                                                                        |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Evangeline Faulkner - wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         |                                                                                                                                                                       |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4703 Post Road - Baltimore, Maryland 21215</b>                                                                                                                                                       |                                                            |                                                                                                        |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>                                                                      |                                                                            | 20c. Location - City or Town, State<br><b>Owings Mills, Maryland</b>                                                                                                                                                                                                                                     |                                                            | 20d. Date<br><b>7/26/2000</b>                                                                          |                                                             |  |
| 21. Signature of Funeral Service Licensee<br><b>James M. Wallace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                                                                                                                                       |                                                                            | 22. Name and Address of Facility<br><b>Nancy M. Wallace Funeral Service<br/>3405 W. Franklin Street - Baltimore, Maryland 21229</b>                                                                                                                                                                      |                                                            |                                                                                                        |                                                             |  |
| 23a. Part I. Explain the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hypertensive Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |                                                                                         |                                                                                                                                                                       |                                                                            | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                             |                                                            |                                                                                                        |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |                                                                                                                                                                       |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                         |                                                            |                                                                                                        |                                                             |  |
| 24a. Was an autopsy performed?<br><b>INSPECTION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |                                                                                                                                                                       |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                  |                                                            |                                                                                                        |                                                             |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                                                                                                                                       |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                            |                                                                                                        |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                           |                                                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                                                |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                          |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                       |                                                             |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                             |                                                            |                                                                                                        |                                                             |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                            |                                                                                         |                                                                                                                                                                       |                                                                            | 29b. Signature and title of certifier<br><b>Stephen A. Radentz, M.D.</b>                                                                                                                                                                                                                                 |                                                            |                                                                                                        |                                                             |  |
| 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |                                                                                                                                                                       |                                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 22, 2000</b>                                                                                                                                                                                                                                              |                                                            |                                                                                                        |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                                                                                                                                       |                                                                            | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                  |                                                            |                                                                                                        |                                                             |  |
| 32. Registrar's Signature<br><b>Barbara B. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         |                                                                                                                                                                       |                                                                            | 33. State Registrar<br><b>Maryland</b>                                                                                                                                                                                                                                                                   |                                                            |                                                                                                        |                                                             |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23188

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br>James Bernard Feldman Jr                   |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 | 2. Date of Death<br>Month Day Year<br>July 13 2000       |                                                                                                                                                                                                          | 3. Time of Death<br>5:17 pm                                  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4e. Facility Name (If not institution, give street and number)<br>31 Hickory Nut Court |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 | 4b. City, Town, or Location of Death<br>Baltimore County |                                                                                                                                                                                                          | 4c. County of Death<br>Baltimore                             |                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br>284 18 0389                                               |                                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                  |                                                                                                                                                                                                                                                                                                                 | 7. Age (In yrs. last birthday)<br>Yrs. 77                                                                                                                                                         |                                                                                                                                                 | 8. Date of Birth (Month, Day, Year)<br>December 6 1922   |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Cincinnati, Ohio |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Usual Residence of Decedent                                                            |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        | 10b. County<br>Baltimore                         |                                                                                                                                                             | 10c. City, Town or Location<br>Baltimore County                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                           |                                                              |                                              |
| 10e. Street and Number<br>31 Hickory Nut Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   | 10f. Zip Code<br>21236                                                                                                                          |                                                          | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |                                                              |                                              |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |                                                                                                                                                                                                                                                                                                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                 |                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                              |                                              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) Master's Degree                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                  |                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Nuclear Physicist                                                                                                                                                                                  |                                                                                                                                                                                                   |                                                                                                                                                 | 16b. Kind of Business/Industry<br>B.R.L. Laboratories    |                                                                                                                                                                                                          |                                                              |                                              |
| 17. Father's Name (First, Middle, Last)<br>James B Feldman Sr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Herfel                                                                            |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br>Garnett M. Feldman (Wife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>31 Hickory Nut Court Baltimore, Maryland 21236 |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                  |                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery July 18, 2000                                                                                                                                                                                                       |                                                                                                                                                                                                   | 20c. Location - City or Town, State<br>Baltimore, Maryland                                                                                      |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| 21. Signature of Funeral Service Licensee<br>Katharine S. Harrison                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   | 22. Name and Address of Facility<br>Lassahn Funeral Home Inc<br>7401 Belair Road Baltimore, MD 21236                                            |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Leukemia<br>Due to (or as a consequence of):<br>b. Leukopenia sip chemotherapy<br>Due to (or as a consequence of):<br>c. Thrombocytopenia<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          |                                                                                                                                                                                                          |                                                              | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                              |                                              |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                  |                                                                                                                                                             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                  |                                                                                        |                                                  |                                                                                                                                                             | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                   | 28b. Time of Injury<br>M                                                                                                                        |                                                          | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                  |                                                                                                                                                             | 28d. Describe how Injury occurred                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                   |                                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                  |                                                                                                                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                    |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                         |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| 29b. Signature and title of certifier<br>Katharine S. Harrison MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   | 29c. License number<br>D35712                                                                                                                   |                                                          | 29d. Date signed (Month, Day, Year)<br>7/14/00                                                                                                                                                           |                                                              |                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>K. Harrison MD. Joseph Richey Hospice 820 N. Sutton 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                                                                                                 |                                                          |                                                                                                                                                                                                          |                                                              |                                              |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        | 31. Date filed (Month, Day, Year)<br>JUL 24 2000 |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   | 32. Registrar's Signature<br>Benjamin A. Sparks                                                                                                 |                                                          |                                                                                                                                                                                                          |                                                              |                                              |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23189

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS A. GIBBS

2. Date of Death

Month Day Year  
July 16 2000

3. Time of Death

2214

4a. Facility Name (If not institution, give street and number)

Memorial Hospital Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

219-36-5590

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 17, 1942

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 235

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

chef

16b. Kind of Business/Industry

restaurant

17. Father's Name (First, Middle, Last)

Thomas M. Gibbs

18. Mother's Name (First, Middle, Maiden Surname)

Sara E. Eldridge

19a. Informant's Name/Relationship (Type, Print)

Jackie Gibbs/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 235 Easton, MD 21601

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30-60 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic coronary artery disease

Due to (or as a consequence of):

5-10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Chronic renal failure

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Lawrence D. Bohan MD

29c. License number

D 27409

29d. Date signed (Month, Day, Year)

7-17-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LAWRENCE D. BOHAN Memorial Hosp. EASTON

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Lawrence D. Bohan

State  
Registrar

ORIGINAL

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23190

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Wayne Gary

2. Date of Death

Month  
JulyDay  
15Year  
2000

3. Time of Death

6:00 P.M.

4a. Facility Name (If not institution, give street and number)

802 Creek Road

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216 62 8199

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Aug. 30, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

802 Creek Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Limousine

17. Father's Name (First, Middle, Last)

Allen L. Gary

18. Mother's Name (First, Middle, Maiden Surname)

Mary Shellie

19a. Informant's Name/Relationship (Type, Print)

Lori Cullotta / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 Dorchester Road Glen Burnie, Maryland 21060

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp.

Date

7/18/00

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Carcinoma

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIV disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify): HOSPICE

27. Manner of Death

☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33624

29d. Date signed (Month, Day, Year)

7/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN J. DOWNS, M.D. 7505 ASLER DRIVE STE 302 TOWSON MD 21204

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Brenda G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-251-2000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23191

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Irene Greene

2. Date of Death

July 20, 2000 14:52

3. Time of Death

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

none

Funeral  
Director

5. Social Security Number

215-22-8581

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 29, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

none

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

111 N Edgewood Street

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Bernard Smith

18. Mother's Name (First, Middle, Maiden Surname)

Viola Holt Smith

19a. Informant's Name/Relationship (Type, Print)

Harold Linwood Greene

Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 N. Edgewood Street Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

7/25/00

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

Shirley M. Greene

22. Name and Address of Facility

Shirley M. Greene Funeral Service  
3405 W. Franklin St. Baltimore 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Shirley M. Greene, Attending Physician

29c. License number

DS1853

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Silverman, MD 900 Caton Avenue Baltimore 21229

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23192

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry H. Hinks

2. Date of Death

July

Day

20

Year

2000

3. Time of Death

0417 AM

4a. Facility Name (If not institution, give street and number)

Saint Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

212-14-1283

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jul 26, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3204 Hilltop Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Charles William Hinks

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Edler

19a. Informant's Name/Relationship (Type, Print)

Helen Hinks / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3204 Hilltop Avenue, Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

7/24/2000 Baltimore, Maryland

21. Signature of Funeral Service Licensee

Juanita R. Thomas

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ruptured Abdominal Aortic Aneurysm

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. K. Fraji, Jr. MD

29c. License number

P10878

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Elic K. Fraji, Jr.

Saint Agnes Hospital

900 Canton Ave.

Baltimore, Md. 21229.

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME HARRY H. HINKS

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 00 23193

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RENEE VANESSA HURTT

2. Date of Death

Month Day Year  
JULY 22, 2000

3. Time of Death

3:15 P.M.

4a. Facility Name (If not institution, give street and number)

1218 GLENBACK ROAD

4b. City, Town, or Location of Death

PIKESVILLE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

212-62-7558

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6/11/55

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PIKESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1218 GLENBACK ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

VAN MADDEN

18. Mother's Name (First, Middle, Maiden Surname)

MARY WALLACE

19a. Informant's Name/Relationship (Type, Print)

JOSEPH R. HURTT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1218 GLENBACK ROAD PIKESVILLE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MORELAND MEMORIAL PARK

Date

7/26/00

20c. Location - City or Town, State

HILLENDALE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Endstage renal disease  
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bacterial endocarditis  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Patrice Green MD

29c. License number

D-54018

29d. Date signed (Month, Day, Year)

July 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrice Green, MD 3301 Calvert Street Baltimore, MD

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Patrice Green

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM# 26 PER ME0. G786 7-24-00 WB  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

00 23194

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Alleen Handy</b>                                 |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   |                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 18, 2000</b> |                                                                                                    | 3. Time of Death<br><b>5:40pm</b>                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>1715 East 33rd. Street</b> |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   |                                                                              | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                                                                                    | 4c. County of Death<br><b>NA</b>                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>215-22-0641</b>                                                 |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                                        | 7. Age (In yrs. last birthday)<br><b>74</b>                                                                                                                                                       |                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>07-13-26</b>     |                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                     |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 | 10b. County<br><b>NA</b> |                                                                                                                                                       | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   |                                                                              |                                                            | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                       |  |
| 10e. Street and Number<br><b>1715 E. 33rd. Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                          |                                                                                                                                                       | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                   | 10g. Citizen of What Country?<br><b>USA</b>                                  |                                                            |                                                                                                    |                                                       |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                              |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                            |                                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b><br>College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                          |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                                                                                                                                                                                          |                                                                                                                                                                                                   |                                                                              | 16b. Kind of Business/Industry<br><b>in home</b>           |                                                                                                    |                                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Allan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine Henson</b> |                                                            |                                                                                                    |                                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathy D. Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                          |                                                                                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21218</b><br><b>1715 E. 33rd. Street Baltimore, Maryland</b>                                                                                                                                                          |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                          |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>                                                                                                                                                                                                                   |                                                                                                                                                                                                   | 20c. Location - City or Town, State<br><b>07-22-2000 Baltimore, MD</b>       |                                                            |                                                                                                    |                                                       |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                          |                                                                                                                                                       | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C.March FH 1101 E. North Avenue</b>                                                                                                                                                                                                      |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>URINARY TRACT SEPSIS</b><br>Due to (or as a consequence of):<br>b. <b>CARCINOMA OF THE VULVA</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Bronchial asthma</b> |                                                                                                 |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                          |                                                                                                                                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                 |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                          |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>HOSPICE</b> |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                          |                                                                                                                                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                              |                                                            | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                          |                                                                                                                                                       | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                 |                                                                                                                                                                                                   | 28d. Describe how injury occurred                                            |                                                            |                                                                                                    |                                                       |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                          |                                                                                                                                                       | 29b. Signature and title of certifier<br> M.D.                                                                                                                                                                                      |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                          |                                                                                                                                                       | 29c. License number<br><b>D 06933</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br><b>JULY 20<sup>th</sup> 2000</b>      |                                                            |                                                                                                    |                                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN D. MACGIBBON M.D. 300 ARMORY PLACE SUITE 302 BALTIMORE MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                          |                                                                                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                                                      |                                                                                                                                                                                                   |                                                                              |                                                            |                                                                                                    |                                                       |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7/18/00 5:40 pm

ALLEEN HANDY

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23195

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward R. Higgins

2. Date of Death

Month

Day

Year

07

19

2000

3. Time of Death

10:25 PM

4a. Facility Name (If not institution, give street and number)

Knollwood Manor

4b. City, Town, or Location of Death

Millersville

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

307-24-2427

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

August 13, 1926

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

N. Linthicum

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17 Charles Road

10f. Zip Code

21090

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates 1943-1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Electrical Aerospace

17. Father's Name (First, Middle, Last)

Edward R. Higgins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Esther Maschino

19a. Informant's Name/Relationship (Type, Print)

Patrick E. Higgins/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Wyndom Circle, Huckessin, Delaware 19707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

7-22-00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Lisa S. Jefferson

22. Name and Address of Facility

Loudon Park Funeral Home

3620 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Leukemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pancytopenia, Dementia,  
Bacteremia,

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. M. L. D.

29c. License number

D 25000

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Hsin Hung, M.D. 1916 Creek Hwy. SW, #8 Glen Burnie, Md. 21061

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 000-555.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23196

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sheldon E. Haber

2. Date of Death

Month Day Year  
July 18, 2000

3. Time of Death

1:40A.

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

059-26-6421

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 26, 1932

9. Birthplace (State or Foreign Country)

New York, N.Y.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2505 Coach House Way

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher - Ph.D

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Abraham

Haber

18. Mother's Name (First, Middle, Maiden Summa)

Ella

Weider

19a. Informant's Name/Relationship (Type, Print)

Alice Haber (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Beth Tfiloh Cemetery 7/20/2000

Data

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. asperation pneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

48 hrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. cerebral vascular hemorrhage  
Due to (or as a consequence of):

recurrent

c. amyloid angiopathy  
Due to (or as a consequence of):

1991

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 22101

29d. Date signed (Month, Day, Year)

July 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lloyd H. H. H. H. 1475 Lang Ave, Frederick Md

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the General Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

00 23197

Amended Item #12,17,19a per FHG786 8/11/2000 EW

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                           |                                                                                                                                                                                                  |                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>ALFRED HERMANN III</b>                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               | 2. Date of Death<br>Month Day Year<br><b>JULY 17 2000</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>08:16 PM</b>                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>TOWSON</b>     |                                                                                                                                                                                                  | 4c. County of Death<br><b>BALTIMORE</b>                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>213-34-9214</b>                                                           |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.          |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>June 28, 1934</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>Balto. City, MD</b>                                        |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                               | 10b. County<br><b>Baltimore</b>                           |                                                                                                                                                                                                  | 10c. City, Town or Location<br><b>Baldwin</b>               |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | 10e. Street and Number<br><b>13813 Ansari Lane</b>                                                                                                                                                                                                                                          |                                                                            | 10f. Zip Code<br><b>21013</b>                                                                                                                                                                 |                                                           | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                     |                                                                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Vietnam ERA</b>                                                                                                                        |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                          |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4 or 5+) <b>4 years</b>                                                                                                                                                                                                                                                                                               |                                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Insurance Examiner</b>                                                                                                                                                      |                                                                            | 16b. Kind of Business/Industry<br><b>State of MD</b>                                                                                                                                          |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alfred Hermann Jr.</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Lange</b>                                                                                                                        |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruth Hermann (wife)</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13813 Ansari Lane Baldwin, Md 21013</b>                                                   |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                              |                                                                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. John's Lutheran Church Cemetery-Blenheim Long Green, MD</b>                                                                                                                                                |                                                                            | 20c. Location - City or Town, State                                                                                                                                                           |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 21. Signature of Funeral Service Licensee<br><i>E.F. Lassahn</i>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>E.F. Lassahn Funeral Home<br/>11750 Belair Rd. Kingsville, Md 21087</b>                                                                                |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                                           | a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>c. <b>ACUTE LEUKEMIA, NON-LYMPHOID</b><br>Due to (or as a consequence of):<br>d.                                                                            |                                                                            | Approximate Interval Between Onset and Death<br><b>HRS</b><br><br><b>3 DAYS</b>                                                                                                               |                                                           |                                                                                                                                                                                                  |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                               |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                         |                                                                                                           | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                            | 28b. Time of Injury<br>M                                                                                                                                                                      |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                        |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                             |  |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                             |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 29b. Signature and title of certifier<br><i>E.F. Lassahn</i>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            | 29c. License number<br><b>027730</b>                                                                                                                                                          |                                                           | 29d. Date signed (Month, Day, Year)<br><b>7/18/00</b>                                                                                                                                            |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>GARY COHEN, MD. 6569 N. CHARLES ST. BALTO, MD 21204</b>                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                           |                                                                                                                                                                                                  |                                                             |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                     |                                                                            | 32. Registrar's Signature<br><i>James A. Sparks</i>                                                                                                                                           |                                                           |                                                                                                                                                                                                  |                                                             |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23198

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                  |  |                                                                                                                                                   |  |                                                                                                                       |  |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>William W. Harris</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 21 2000</b>                                                                                         |  | 3. Time of Death<br><b>1:30 PM</b>                                                                                    |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                          |  | 4c. County of Death<br><b>NA</b>                                                                                      |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-44-6809</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br><b>1</b> M <b>2</b> F                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.                                                                                                  |  | 8. Date of Birth (Month, Day, Year)<br><b>October 3, 1947</b>                                                         |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10a. State<br><b>MD</b>                                                                                                                                                          |  | 10b. County<br><b>NA</b>                                                                                                                          |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                       |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10e. Street and Number<br><b>116 N. Paca Street Apt 106</b>                                                                                                                      |  | 10f. Zip Code<br><b>21201</b>                                                                                                                     |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                           |  |
|                                               | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRICAN AMERICAN</b>                                    |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>-0-</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ADDITION COUNSELOR RECOVERY HOUSE</b>                            |  | 16b. Kind of Business/Industry                                                                                                                    |  |                                                                                                                       |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>JACK PENSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RUTH HARRIS</b>                                                                                                          |  | 19a. Informant's Name/Relationship (Type, Print) <b>WIFE</b><br><b>Saundra Harris</b>                                                             |  |                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2503 Violet Ave Apt 1003 South, BALTIMORE, MD 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                                       |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion</b>                                                         |  | 20c. Location - City or Town, State<br><b>07-27-00 LINDSEY, MD.</b>                                                   |  |
|                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22. Name and Address of Facility<br><b>WYLIE Funeral Home PA</b><br><b>638 N. Gilman Street BALTIMORE, MD 21217</b>                                                              |  |                                                                                                                                                   |  |                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Fulminant Hepatic Failure</b><br>Due to (or as a consequence of):<br>b. <b>Viral Hepatitis D Infection</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |                                                                                                                                                                                  |  |                                                                                                                                                   |  | Approximate Interval Between Onset and Death<br><b>1 month</b><br><b>1 year</b>                                       |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Autoimmune Deficiency Syndrome</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                  |  |                                                                                                                                                   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                                                                          |  |                                                                                                                                                   |  |                                                                                                                       |  |
|                                               | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |                                                                                                                                                   |  |                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                           |  | 28b. Time of Injury<br><b>M</b>                                                                                                                   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                                                                      |  |
|                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                           |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |  |                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                  |  |                                                                                                                                                   |  | 29b. Signature and title of certifier<br><b>M.D.</b>                                                                  |  |
|                                               | 29c. License number<br><b>AV4176435N9836</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 29d. Date signed (Month, Day, Year)<br><b>July, 21, 2000</b>                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                       |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>University of Maryland, 22 South Green Street, Baltimore. Christopher Nasin MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                  |  |                                                                                                                                                   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                               |  |
|                                               | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                  |  |                                                                                                                                                   |  |                                                                                                                       |  |

ORIGINAL

Page 1 of 1

1. The first part of the document is a letter from the President of the United States to the Congress.

2. The second part of the document is a report on the state of the Union.

3. The third part of the document is a report on the state of the Union.

4. The fourth part of the document is a report on the state of the Union.

5. The fifth part of the document is a report on the state of the Union.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23199

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA T. HASLBECK

2. Date of Death

Month Day Year  
July 17, 2000

3. Time of Death

12:10 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-05-0732

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 10, 1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

accounting

16b. Kind of Business/Industry

lumber

17. Father's Name (First, Middle, Last)

Steven Mogowski

18. Mother's Name (First, Middle, Maiden Surname)

Josephine A. Dobevecz

19a. Informant's Name/Relationship (Type, Print)

Ken Haslbeck/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 MacIntosh Court Baltimore, MD 21220

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. End Stage Congestive Heart Failure

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☒ Other (Specify)

Hospice

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/18/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Benita Sparks

State  
RegistrarJuly 17, 2000 12:10 a.m.  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.Physician  
/Medical  
ExaminerAnna T. Haslbeck  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #17,18 PER ANATOMY BOARD G785 7-24-00 WR. 00 23200

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)  
GERTRUDE B. HOOVER

2. Date of Death  
Month Day Year  
07 16 2000

3. Time of Death  
1116 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)  
Homewood at Crumland Farms

4b. City, Town, or Location of Death  
Frederick

4c. County of Death  
Frederick

5. Social Security Number  
213-10-7434

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
85 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
11-22-1914

9. Birthplace (State or Foreign Country)  
Baltimore

Usual Residence of Decedent

10a. State  
MD

10b. County  
Frederick

10c. City, Town or Location  
Frederick

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
7404 Willow Road

10f. Zip Code  
21702

10g. Citizen of What Country?  
USA

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: white

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
12 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
housewife

16b. Kind of Business/Industry  
none

17. Father's Name (First, Middle, Last)  
unk JOHN BAUER

18. Mother's Name (First, Middle, Maiden Surname)  
unk MARGARET FUNK

19a. Informant's Name/Relationship (Type, Print)  
Joan A. Wilson/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
876 Washington Blvd #202 Baltimore, MD 21230

20a. Method of Disposition  
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee  
Joseph B. Van Sant

22. Name and Address of Facility  
State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)  
a. Liver failure  
Due to (or as a consequence of):

2 days

b. Chylous ascites  
Due to (or as a consequence of):

2 months

c. Cirrhosis of liver  
Due to (or as a consequence of):

unknown

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

CVA

GI bleed

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
29b. Signature and Title of Certifier  
29c. License number  
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  
300 W 9th St, Frederick MD 21701

31. Date filed (Month, Day, Year)  
JUL 24 2000

32. Registrar's Signature  
penner P Sparks

State  
Registrar

Name known to Physician  
Gertrude B. Hoover  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

X - X

10/10

10/10

10/10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23201

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>VERNON JOHNSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 2. Date of Death<br>Month <b>7</b> Day <b>18</b> Year <b>2000</b>                                                                                                                            |  |                                                                                             |                                                                                    | 3. Time of Death<br><b>1632</b>                                                                                                                                                                  |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL SYSTEM</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                     |  |                                                                                             |                                                                                    | 4c. County of Death<br><b>BALTIMORE CITY</b>                                                                                                                                                     |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>29-86-1667</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>September 1, 1937</b>                             |                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                            |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                             |                                                                                                                                         | 10c. City, Town or Location<br><b>Woodlawn</b>                                                                                                                                               |  |                                                                                             |                                                                                    | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |  |
|                                               | 10e. Street and Number<br><b>2121 Windom Blvd C224</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 10f. Zip Code<br><b>21207</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b> |                                                                                                                                                                                                  |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>-0-</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Stationary Engineer</b> |                                                                                                                                                                                              |  | 16b. Kind of Business/Industry<br><b>Scrapyard</b>                                          |                                                                                    |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Thomas B. Johnson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen M. Smith</b>                                                                                                                   |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gertrude Nock sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3801 Oakford Ave Apt E Balto MD 21215</b>                                                |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Ph 7/22/00 Baltimore, MD</b>                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                                                              |  | 20c. Location - City or Town, State                                                         |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 22. Name and Address of Facility<br><b>Wm General Home PA 638 N. Baltimore St Balto, MD 21217</b>                                                                                            |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>VENTRICULAR TACHYCARDIA</b><br>Due to (or as a consequence of):<br>b. <b>PANCYTOPENIA</b><br>Due to (or as a consequence of):<br>c. <b>FUNGEMIA</b><br>Due to (or as a consequence of):<br>d. <b>PNEUMONIA</b> |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
|                                               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                               |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                         | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                    | 28d. Describe how injury occurred                                                                                                                                                                |  |
|                                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | 29s. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                             |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
| State Registrar                               | 29b. Signature and title of certifier<br><b>Ryan McCormack</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 29c. License number<br><b>13112</b>                                                                                                                                                          |  | 29d. Date signed (Month, Day, Year)<br><b>7/18/00</b>                                       |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RYAN MCCORMACK 22 S. GREENE ST., BALTIMORE, MD 21201</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                              |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |
|                                               | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                              |  |                                                                                             |                                                                                    |                                                                                                                                                                                                  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23202

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                          |                                                                              |                                                                  |                          |                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>THELMA JACKSON                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           | 2. Date of Death<br>Month Day Year<br>JULY 19, 2000                                                                                                                                                      |                                                                              |                                                                  |                          | 3. Time of Death<br>2:45 PM                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Gilchrist Center                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           | 4b. City, Town, or Location of Death<br>Baltimore                                                                                                                                                        |                                                                              |                                                                  |                          | 4c. County of Death<br>Baltimore                                                                                                            |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>212-38-4711                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                    | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                  |                                                                                                                                                                                                                                                                                           | 7. Age (In yrs. last birthday)<br>89 Yrs.                                                                                                                                                                |                                                                              | If Under 1 Year<br>Months Days                                   |                          | If Under 24 Hrs.<br>Hours Min.                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br>May 24, 1911                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br>MD                                                                                                                                                  |                                                                                                                                                                                                                                                                                           | 10a. State<br>MD                                                                                                                                                                                         |                                                                              | 10b. County<br>N/A                                               |                          | 10c. City, Town or Location<br>Baltimore                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                    | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                              |                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br>2207 E. Coldspring Lane                                                                                                                                                        |                                                                              | 10f. Zip Code<br>21214                                           |                          | 10g. Citizen of What Country?<br>USA                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                           |                                                                                                                                                                                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: black |                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (14 or 5+) 4                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>educator                                                                           |                                                                                                                                                                                                                                                                                           | 16b. Kind of Business/Industry<br>education                                                                                                                                                              |                                                                              |                                                                  |                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Edward M. Dorsey                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carrie E. Dorsey                                                                                                                                    |                                                                              |                                                                  |                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Gilchrist Center                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6601 N. Charles Street Baltimore, MD 21204                                                              |                                                                              |                                                                  |                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                          |                                                                                                                                                                                                                                                                                           | Data                                                                                                                                                                                                     |                                                                              | 20c. Location - City or Town, State                              |                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Joseph B. Van Sant                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    | 22. Name and Address of Facility<br>State Anatomy Board 655 W. Baltimore Street<br>Baltimore, MD 21201                                                                                          |                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                          |                                                                              |                                                                  |                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                                    | a. renal failure<br>Due to (or as a consequence of):<br>b. congestive heart failure<br>Due to (or as a consequence of):<br>c. ischemic cardiomyopathy<br>Due to (or as a consequence of):<br>d. |                                                                                                                                                                                                                                                                                           | Approximate Interval Between Onset and Death<br>weeks<br>years<br>year                                                                                                                                   |                                                                              |                                                                  |                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                              |                                                                  |                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                                              |                                                                  |                          | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |                                                                                                                                                                                                 | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |                                                                                                                                                                                                          | 28a. Date of Injury (Month, Day Year)                                        |                                                                  | 28b. Time of Injury<br>M |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                               |                                                                                                                                                                                                 | 28d. Describe how injury occurred                                                                                                                                                                                                                                                         |                                                                                                                                                                                                          | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                  |                          |                                                                                                                                             |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 29b. Signature and title of certifier<br>Dr. Anthony Riley, MD                                                                                                                                                                                                                                                     |                                                                                                                                                                                                 | 29c. License number<br>D25205                                                                                                                                                                                                                                                             |                                                                                                                                                                                                          | 29d. Date signed (Month, Day, Year)<br>July 19, 2000                         |                                                                  |                          |                                                                                                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>W.A. Riley Home 6701 N. Charles St. Balto. MD 21204                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 31. Date filed (Month, Day, Year)<br>JUL 24 2000                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                 | 32. Registrar's Signature<br>B Sparks                                                                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                              |                                                                  |                          |                                                                                                                                             |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23203

AMEND#20C PER F.H. G785 7-27-2000 JAB

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALVIN FRANCIS KNIGHT, SR.

2. Date of Death

Month Day Year  
JULY 20, 2000

3. Time of Death

10.05 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

579-14-8887

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

APRIL 15, 1919 VIRGINIA

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1614 SEVERN ROAD

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Aged Forcibly?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

1944-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WELDER

16b. Kind of Business/Industry

PLASTICS COMPANY

17. Father's Name (First, Middle, Last)

GEORGE

WASHINGTON

KNIGHT

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE

MERRYMAN

19a. Informant's Name/Relationship (Type, Print)

MRS. MARY KNIGHT (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1614 SEVERN ROAD, SEVERN, MARYLAND 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHELTENHAM VETERANS CEMETERY

Date

JULY 26, 2000

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, P.A.,  
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. EMPHYSEMA

Due to (or as a consequence of):

5 YRS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

P51245

29d. Date signed (Month, Day, Year)

JULY 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAJID SITARIF NORTH ARUNDEL HOSPITAL - GLEN BURNIE - MD

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Benjamin A. Sparks

State  
Registrar

ORIGINAL

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

46



Elizabeth Krausz

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G785 7-28-00 MR. **Certificate of Death**

Reg. No.

00 23204

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH MAY KRAUSZ</b>                                                                                                                                                                                                                                                                                                                                                      |  | 2. Date of Death<br>Month Day Year<br><b>July 16, 2000</b>                                                                                                                                                                                                                                                  |  | 3. Time of Death<br><b>6:13 p.m.</b>                                                                                                                                                         |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1322 Howard Road</b>                                                                                                                                                                                                                                                                                                                                    |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>                                                                                                                                                                                                                                                  |  | 4c. County of Death<br><b>Anne Arundel</b>                                                                                                                                                   |  |
| 5. Social Security Number<br><b>212-32-5767</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.                                                                                                                                             |  |
| 8. Date of Birth (Month, Day, Year)<br><b>DEC. 5, 1933</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                              |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. County<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                                                          |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>                                                                                                                                            |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 10e. Street and Number<br><b>1322 HOWARD ROAD</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 10f. Zip Code<br><b>21061</b>                                                                                                                                                                                                                                                                               |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b><br>College (1-4or 5+) <b>College (1-4or 5+)</b>                                                                                                                                                                                                                                                                      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                                                                                                                                                                               |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                                                                                                                            |  |
| 17. Father's Name (First, Middle, Last)<br><b>GEORGE HILDEBRAND</b>                                                                                                                                                                                                                                                                                                                                                          |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JUANITA HALL</b>                                                                                                                                                                                                                                    |  |                                                                                                                                                                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. JANE HUDGINS (DAUGHTER)</b>                                                                                                                                                                                                                                                                                                                                      |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>284 OAKWOOD VILLAGE COURT, GLEN BURNIE, MD. 21061</b>                                                                                                                                                   |  |                                                                                                                                                                                              |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK 2000</b>                                                                                                                                                                                              |  | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD.</b>                                                                                                                               |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                              |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                                                                                                                                                                                  |  |                                                                                                                                                                                              |  |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                             |  | Approximate Interval Between Onset and Death                                                                                                                                                 |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>                                                                                                                                                                                                                                                                                                             |  | Due to (or as a consequence of):                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                   |  | Due to (or as a consequence of):                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Due to (or as a consequence of):                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Due to (or as a consequence of):                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b> |  |                                                                                                                                                                                              |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>                                                                                                                                                                                                                                                           |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                              |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                |  |                                                                                                                                                                                              |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                 |  | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                      |  | 29d. Date signed (Month, Day, Year)<br><b>July 20, 2000</b>                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. Registrar's Signature<br>                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 23205

AMEND#21 PER. A.B. &amp;24A PER MD. G785 7-24-2000 JAB

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br><b>Baby Boy Lewis Twin B</b>                      |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               | 2. Date of Death<br>Month Day Year<br><b>03 - 16 - 00</b> |                                                                         | 3. Time of Death<br><b>7:00pm</b>                      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br><b>Mercy Medical Center</b> |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                                         | 4c. County of Death<br><b>Baltimore City</b>           |                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                        | 5. Social Security Number<br><b>none</b>                                                      |                                                                                                                                                                                  | 6. Sex<br><b>1</b> M <b>2</b> F |                                                                                                                                                   | 7. Age (In yrs. last birthday)<br>Yrs.<br><b>0</b> <b>16</b> |                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>3/16/00</b>     |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Md.</b> |                                              |
|                                                                                                                                                                                                                                                                                                                                                                            | Usual Residence of Decedent                                                                   |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 10a. State<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                               | 10b. County<br><b>Baltimore City</b>                                                                                                                                             |                                 | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                   |                                                              |                                                                                                                                               |                                                           | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                     |                                                        |                                              |
| 10e. Street and Number<br><b>4919 Alhambra Ave</b>                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                                                                                  |                                 | 10f. Zip Code<br><b>21212</b>                                                                                                                     |                                                              |                                                                                                                                               |                                                           | 10g. Citizen of What Country?<br><b>USA</b>                             |                                                        |                                              |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                                                                                                                                                                                                                                                        |                                                                                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                                                                           |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |                                                              |                                                                                                                                               |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |                                                        |                                              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>none</b> College (1-4or 5+) <b>none</b>                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                                                                                  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>none</b>                          |                                                              |                                                                                                                                               |                                                           | 16b. Kind of Business/Industry<br><b>none</b>                           |                                                        |                                              |
| 17. Father's Name (First, Middle, Last)<br><b>Darrell Lewis</b>                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Johanna Lewis</b>                                                                     |                                                           |                                                                         |                                                        |                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mercy Medical Center</b>                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>301 St. Paul Place Baltimore MD 21201</b> |                                                           |                                                                         |                                                        |                                              |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify) <b>IN STATE</b>                                                                                                                                                                                                                 |                                                                                               |                                                                                                                                                                                  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                            |                                                              | Date                                                                                                                                          |                                                           | 20c. Location - City or Town, State                                     |                                                        |                                              |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                                                                                  |                                 | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                                        |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                  |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)<br><b>e. Extreme Prematurity</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                       |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                     |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                                                                                                                                                                                                                                                      |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                     |                                                                                               | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide                                                                                                                                                                                                         |                                                                                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                           |                                 | 28b. Time of Injury<br>M                                                                                                                          |                                                              | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                                                                                              |                                                           | 28d. Describe how injury occurred                                       |                                                        |                                              |
|                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                           |                                 |                                                                                                                                                   |                                                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                  |                                                           |                                                                         |                                                        |                                              |
| 29a. Certifier (Check only one)<br><b>1</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                                                                                                                                                  |                                 | 29c. License number<br><b>D42001</b>                                                                                                              |                                                              | 29d. Date signed (Month, Day, Year)<br><b>03-21-00</b>                                                                                        |                                                           |                                                                         |                                                        |                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mercy Medical Center</b><br><b>301 St. Paul Place, Balto., Md. 21202</b>                                                                                                                                                                                                        |                                                                                               |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                    |                                                                                               | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                  |                                 |                                                                                                                                                   |                                                              |                                                                                                                                               |                                                           |                                                                         |                                                        |                                              |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23206

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARJORY H. KEETER

2. Date of Death  
Month Day Year

July 22 2000 1:30AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

LORIEN NURSING HOME

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

463-14-7098

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 13, 1917

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

503 Stavey Hill Court

10f. Zip Code

21113

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Monte Clayton

18. Mother's Name (First, Middle, Maiden Surname)

Ona Lee Higgins

19a. Informant's Name/Relationship (Type, Print)

Darwin L. Keeter/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1210 Pine Cone Ct. Severn, MD 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

July 24, 2000

20c. Location - City or Town, State

Brooklyn Park, MD

21. Signature of Funeral Service Licensee

David Leichling

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home P.A.

421 Crain Hwy. S.E. Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. STROKE

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

50 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Leichling M.D.

29c. License number

D29888

29d. Date signed (Month, Day, Year)

JULY 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID LEICHLING 2 KNOLL N. COLUMBIA MD 21045

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

David Leichling

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene 00 23207

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                           |                                                     |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>WILBERT H. LEWIS, SR.                        |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        | 2. Date of Death<br>Month Day Year<br>JULY 17, 2000 |                                                                                                                                                           | 3. Time of Death<br>0910                            |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>1443 WASHINGTON AVENUE |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        | 4b. City, Town, or Location of Death<br>SEVERN      |                                                                                                                                                           | 4c. County of Death<br>ANNE ARUNDEL                 |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>220-01-9782                                                 |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                        | 7. Age (In yrs. last birthday)<br>78 Yrs.           |                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br>JAN. 7, 1922 |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br>MARYLAND                                     |                                                                                                                                                                                                                                                                                                         | 10a. State<br>MARYLAND                                                         |                                                                                                                                                                                                                                                                                        | 10b. County<br>ANNE ARUNDEL                         |                                                                                                                                                           | 10c. City, Town or Location<br>SEVERN               |                                              |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                      |                                                                                | 10e. Street and Number<br>1443 WASHINGTON AVENUE                                                                                                                                                                                                                                       |                                                     | 10f. Zip Code<br>21144                                                                                                                                    |                                                     | 10g. Citizen of What Country?<br>U.S.A.      |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                             |                                                                                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1944-1945                                                                                                                                         |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                       |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                                                                          |                                                     |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                              |                                                                                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>OWNER                                                                                                                                                                                      |                                                                                | 16b. Kind of Business/Industry<br>ACE HARDWARE                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                           |                                                     |                                              |  |
| 17. Father's Name (First, Middle, Last)<br>RICHARD LEWIS                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>NETTIE JONES                                                                                                                                                                                                                      |                                                     |                                                                                                                                                           |                                                     |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>MRS. DORIS LEWIS (WIFE)                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1443 WASHINGTON AVENUE, SEVERN, MARYLAND 21144                                                                                                                                        |                                                     |                                                                                                                                                           |                                                     |                                              |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                    |                                                                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GLEN HAVEN MEMORIAL PARK 7/21/2000 GLEN BURNIE, MD.                                                                                                                                                                           |                                                                                | 20c. Location - City or Town, State                                                                                                                                                                                                                                                    |                                                     |                                                                                                                                                           |                                                     |                                              |  |
| 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br>SINGLETON FUNERAL HOME, P.A.,<br>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061                                                                                                                                                                     |                                                     |                                                                                                                                                           |                                                     |                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                          | a. Arteriosclerotic Heart Disease years<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.                                                                                                                             |                                                                                |                                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                           |                                                     | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                             |                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                               |                                                     |                                                                                                                                                           |                                                     |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                              |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                     |                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                              |                                                                                          | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |                                                     | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                     | 28d. Describe how injury occurred            |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                      |                                                                                          | 29b. Signature and title of certifier<br>William P. Jones, Deputy Medical Examiner                                                                                                                                                                                                                      |                                                                                | 29c. License number<br>D 06054                                                                                                                                                                                                                                                         |                                                     | 29d. Date signed (Month, Day, Year)<br>7/17/00                                                                                                            |                                                     |                                              |  |
| 30. Name and address of person who completed/cause of death (Item 23a) (Type, Print)<br>DR. WILLIAM P. JONES, DEPUTY MEDICAL EXAMINER, 6131 SHADY SIDE ROAD, SHADY SIDE, MD 20764                                                                                                                                                                                                                                                                  |                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                | 31. Date filed (Month, Day, Year)<br>JUL 24 2000                                                                                                                                                                                                                                       |                                                     | 32. Registrar's Signature<br>[Signature]                                                                                                                  |                                                     |                                              |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 23208

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRED LITTLE

2. Date of Death

Month Day Year

July 11, 2000

3. Time of Death

545 pm

4a. Facility Name (If not Institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

239-38-5433

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 21, 1930

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 Dolphin Street #212

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

bulldozer driver

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Maryland General Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

827 Linden Ave Baltimore, MD 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Airway Disease

Due to (or as a consequence of):

c. Diabetes Mellitus Insulin Dependent

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Junhui Gong MD

29c. License number

89372

29d. Date signed (Month, Day, Year)

7/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Junhui Gong, M.D. to Maryland General Hospital

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23209

## Certificate of Death

Reg. No.

|                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>Edward Lawrence</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                |  | 2. Date of Death<br>Month <b>July</b> Day <b>18</b> Year <b>2000</b>                                                                                                                         |  | 3. Time of Death<br><b>2:05pm</b>                                                              |  |
|                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                     |  | 4c. County of Death<br><b>N/A</b>                                                              |  |
| Funeral<br>Director                                                                                                                     | 5. Social Security Number<br><b>163-18-1439</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                     |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 20, 1919</b>                                     |  |
|                                                                                                                                         | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. County<br><b>Baltimore</b>                                                                                                                                |  | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                              |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                                                                                     | 10e. Street and Number<br><b>11 Church Lane #11</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                |  | 10f. Zip Code<br><b>21208</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>USA</b>                                                    |  |
|                                                                                                                                         | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                       |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>42-43</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
|                                                                                                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>                                                                                                                                                                                                                                                                                  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unk</b>                                        |  | 16b. Kind of Business/Industry<br><b>unk</b>                                                                                                                                                 |  |                                                                                                |  |
|                                                                                                                                         | 17. Father's Name (First, Middle, Last)<br><b>William J. Lawrence</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emily Arnett</b>                                                                                                                     |  |                                                                                                |  |
|                                                                                                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sinai Hospital</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2401 W. Belvedere Ave Baltimore, MD 21215</b>                                            |  |                                                                                                |  |
|                                                                                                                                         | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                         |  | 20c. Location - City or Town, State                                                                                                                                                          |  |                                                                                                |  |
|                                                                                                                                         | 21. Signature of Funeral Service Licensee<br><b>Joseph B. Van Sant</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                                                                                   |  |                                                                                                |  |
|                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
| Physician<br>/Medical<br>Examiner                                                                                                       | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>nephrolithiasis</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                         | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                         | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                         |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
|                                                                                                                                         | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                         |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |  |                                                                                                |  |
|                                                                                                                                         | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                         | 29b. Signature and title of certifier<br><b>Ledys Julia Valle MD</b>                                                                                                                                                                                                                                                                                                                                                      |  | 29c. License number<br><b>P14288</b>                                                                                                                           |  | 29d. Date signed (Month, Day, Year)<br><b>July 18 2000</b>                                                                                                                                   |  |                                                                                                |  |
|                                                                                                                                         | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ledys Julia Valle MD 21215 Sinai Hospital of Baltimore 2401 West Belvedere Avenue Baltimore Maryland</b>                                                                                                                                                                                                                       |  |                                                                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                         | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                |  |                                                                                                                                                                                              |  |                                                                                                |  |

ORIGINAL





00-3966-510

DARREN

MONTGOMERY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23210

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Darren Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  | 2. Date of Death<br>Month Day Year<br><b>JULY 18, 2000</b>                                                                                                                                    |  | 3. Time of Death<br><b>3:06 P.M.</b>                                                                                                                                                             |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1618 HARTSDALE ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 4b. City, Town, or Location of Death<br><b>BAITMORE</b>                                                                                                                                       |  | 4c. County of Death<br><b>NA</b>                                                                                                                                                                 |  |
| 5. Social Security Number<br><b>217-94-5705</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F<br><b>XX</b>                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br>Yrs. <b>28</b>                                                                                                                                              |  | 8. Date of Birth (Month, Day, Year)<br><b>07-23-71</b>                                                                                                                                           |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. County<br><b>NA</b>                                                                                                                                                                                                                                                                                 |  | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                               |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |  |
| 10e. Street and Number<br><b>1618 Hartsdale Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  | 10f. Zip Code<br><b>21239</b>                                                                                                                                                                 |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                        |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                          |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auto Mechanic</b>                                                             |  | 16b. Kind of Business/Industry<br><b>Midas Company</b>                                                                                                                                           |  |
| 17. Father's Name (First, Middle, Last)<br><b>Willard Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mender Thornton</b>                                                                                                                   |  |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Diane W. Thornton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2823 E. Federal Street Baltimore, Maryland 21213</b>                                      |  |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetary</b>                                                                                                                                                                                                       |  | 20c. Date<br><b>07-27-2000</b>                                                                                                                                                                |  | 20d. Location - City or Town, State<br><b>Lansdowne, MD</b>                                                                                                                                      |  |
| 21. Signature of Funeral Service Licensee<br><b>Gabrielle Curo</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                          |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202<br/>WM.C.March FH 1101 E. North Avenue</b>                                                                                   |  |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>INTRACRANIAL GUNSHOT WOUND</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                               |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28a. Date of Injury (Month, Day, Year)<br><b>7/18/00</b>                                                                                                                                                                                                                                                 |  | 28b. Time of Injury<br><b>1359</b> M                                                                                                                                                          |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28d. Describe how injury occurred<br><b>SUBJECT SHOT SELF IN MOUTH</b>                                                                                                                                                                                                                                   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RESIDENCE</b>                                                                                    |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1618 HARTSDALE ROAD BALTIMORE MD</b>                                                                          |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                           |  | 29b. Signature and title of certifier<br><b>Mary G. Ripple, M.D.</b>                                                                                                                                                                                                                                     |  | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 19, 2000</b>                                                                                                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2020.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23211

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>CHRISTINE MARIE NARKIEWICZ McDONALD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            | 2. Date of Death<br>Month Day Year<br>July 20 2000                                                                                                                                               |                                                                                                           | 3. Time of Death<br>05:05 P.M.                      |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            | 4b. City, Town, or Location of Death<br>Hagerstown                                                                                                                                               |                                                                                                           | 4c. County of Death<br>Washington                   |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>202-44-0043                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                            | 7. Age (In yrs. last birthday)<br>47 Yrs.                                                                                                                                                        |                                                                                                           | 8. Date of Birth (Month, Day, Year)<br>Nov 18, 1952 |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                           |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 10b. County<br>Frederick                                                                                                                              |                                                                                                                                            | 10c. City, Town or Location<br>Jefferson                                                                                                                                                         |                                                                                                           |                                                     |                                                                                                                                                                                                          | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>4640 Newington Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            | 10f. Zip Code<br>21755                                                                                                                                                                           |                                                                                                           | 10g. Citizen of What Country?<br>USA                |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                           |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Geo-Tech                                                                            |                                                                                                           |                                                     | 16b. Kind of Business/Industry<br>Civil Engineering                                                                                                                                                      |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Walter Narkiewicz                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen Mujwit                                                                                                                                |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Dennis McDonald (Husband)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4640 Newington Road, Jefferson, MD 21755                                                        |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St Joseph's R.C. Cemetery                                                                                              |                                                                                                           |                                                     | 20c. Location - City or Town, State<br>New Brighton 15066PA                                                                                                                                              |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Martin D. Lawson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home, Inc.<br>6500 York Road, Baltimore, Maryland                                                                                 |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Multiple injuries<br>Due to (or as a consequence of):<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  | Approximate Interval Between Onset and Death |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                  |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  |                                                                                                           |                                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                   |                                                                                                    |  |                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28a. Date of Injury (Month, Day, Year)<br>7/20/00                                                                                                                                                                                                                                                       |                                                                                                                                                       | 28b. Time of Injury<br>08:40 AM                                                                                                            |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No           |                                                     | 28d. Describe how injury occurred during which involved in vehicle accident                                                                                                                              |                                                                                                    |  |                                              |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>roadway                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Route 15 at Mitchell Road, P.O. Box 1, Rockville, Maryland |                                                                                                                                                                                                  |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
| 29b. Signature and title of certifier<br>Theodore H. King                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 29c. License number<br>O.C.M.E.                                                                                                            |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br>July 23, 2000                                                      |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>THEODORE H. KING 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                                                                                                                  |                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                                  |                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                                                                    |  |                                              |  |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23212

|                                                                      |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH MESSINA</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>July 16 2000</b>   |                                                                         | 3. Time of Death<br><b>7:00 PM</b>                    |                                                                                                 |                                                |                                   |  |
|                                                                      | 4a. Facility Name (If not institution, give street and number)<br><b>Lorien Nursing and Rehab</b> |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Columbia</b>     |                                                                         | 4c. County of Death<br><b>Howard</b>                  |                                                                                                 |                                                |                                   |  |
| Funeral<br>Director                                                  | 5. Social Security Number<br><b>173-34-1377</b>                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                       | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs. |                                                                                                                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br><b>July 14, 1904</b> |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>PA</b> |                                                                                                 |                                                |                                   |  |
|                                                                      | Usual Residence of Decedent                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         | 10a. State<br><b>MD</b>                                     |                                                                         | 10b. County<br><b>Howard</b>                          |                                                                                                 | 10c. City, Town or Location<br><b>Columbia</b> |                                   |  |
| To Be Completed by Funeral Director                                  |                                                                                                   | 10e. Street and Number<br><b>6336 Cedar Lane</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                                                       |                                                  | 10f. Zip Code<br><b>21044</b>                                                                                                                                                                                                                                                                           |                                                             | 10g. Citizen of What Country?<br><b>USA</b>                             |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                        |                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                        |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                                                       |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>beautician</b>                                                                                                                                                                          |                                                             | 16b. Kind of Business/Industry<br><b>self employed'</b>                 |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 17. Father's Name (First, Middle, Last)<br><b>Vincent Barkauskas</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                                                       |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Katiluis</b>                                                                                                                                                                                                                              |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lorien Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                                                       |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6336 Cedar Lane, Columbia, MD 21044</b>                                                                                                                                                             |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |                                                                                |                                                                                                                                                       |                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                                  |                                                             | Date                                                                    |                                                       | 20c. Location - City or Town, State                                                             |                                                |                                   |  |
|                                                                      |                                                                                                   | 21. Signature of Funeral Service Licensee<br><b>Joseph B. Van Sant</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                       |                                                  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                                                                                                                                                                                              |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                     |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
| Physician<br>/Medical<br>Examiner                                    |                                                                                                   | Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                       |                                                  | a. <b>myocardial infarction - EMB Stage 2</b>                                                                                                                                                                                                                                                           |                                                             |                                                                         |                                                       | Approximate Interval Between Onset and Death<br><b>yes</b>                                      |                                                |                                   |  |
|                                                                      |                                                                                                   | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner |                                                                                                   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Valvular Heart Disease</b>                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                                                       |                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                       |                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                |                                                                                                                                                       |                                                  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                             | 28b. Time of Injury<br><b>M</b>                                         |                                                       | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                | 28d. Describe how injury occurred |  |
|                                                                      |                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                       |                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                                                       |                                                  | 29c. License number<br><b>D-34868</b>                                                                                                                                                                                                                                                                   |                                                             |                                                                         |                                                       | 29d. Date signed (Month, Day, Year)<br><b>July 18, 2000</b>                                     |                                                |                                   |  |
| State<br>Registrar                                                   |                                                                                                   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Diana Stone 11055 Little Potomac Pl Columbia, MD 21044</b>                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |
|                                                                      |                                                                                                   | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                                                       |                                                  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                         |                                                             |                                                                         |                                                       |                                                                                                 |                                                |                                   |  |

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020





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State of Maryland / Department of Health and Mental Hygiene

00 23213

AMEND ITEM #5 PER FH G820 6/17/03 JH

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Hilda P. Miller</b>                        |                                                                                                                                                                                                                                                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>2000</b>                                                                                 |                                                                                                                                                                                              | 3. Time of Death<br><b>4:06 a.m.</b>                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Center</b> |                                                                                                                                                                                                                                                                                                            | 4b. City, Town, or Location of Death<br><b>Towson</b>                                                                                                |                                                                                                                                                                                              | 4c. County of Death<br><b>Baltimore Co.</b>           |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>215-01-4160</b><br><b>215-01-4142</b>                     | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                 | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.                                                                                                     | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 6, 1912</b>                                |                                                                                                                                                                                                                                                                                                            | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                          |                                                                                                                                                                                              |                                                       |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           | 10b. County<br><b>N/A</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                                      | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                              |                                                       |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 10e. Street and Number<br><b>10 East Lee Street Unit 709</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                           |                                                                                                                                                                                                                                                                                                            | 10f. Zip Code<br><b>21202</b>                                                                                                                        |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>United States</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                          |                                                                                                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                       |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                               |                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>                                                                                                                                                                              |                                                                                                                                                      | 16b. Kind of Business/Industry<br><b>Office</b>                                                                                                                                              |                                                       |
| 17. Father's Name (First, Middle, Last)<br><b>David Leo Pessagno</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                           |                                                                                                                                                                                                                                                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara S. Groell</b>                                                                        |                                                                                                                                                                                              |                                                       |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Joseph G. Miller /son</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                           |                                                                                                                                                                                                                                                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 East Lee St. Unit 709 Baltimore, MD 21202</b> |                                                                                                                                                                                              |                                                       |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cem.</b>                                                                                                                                                                                                     |                                                                                                                                                      | 20c. Location - City or Town, State<br><b>7/24/2000 Baltimore, Maryland</b>                                                                                                                  |                                                       |
| 21. Signature of Funeral Service Licensee<br><b>Michael E. Canapp</b><br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                               |                                                                                           | 22. Name and Address of Facility<br><b>LEONARD J. RUCK, INC. Baltimore, Maryland 21214</b><br><b>5305 Harford Road</b>                                                                                                                                                                                     |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. respiratory failure</b><br>Due to (or as a consequence of):<br><b>b. pulmonary fibrosis</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b>                                                                                                                                                    |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| Approximate Interval Between Onset and Death<br><b>months</b><br><b>years</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b> |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                             |                                                                                           | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                      |                                                                                                                                                      | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                       |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                           | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                          |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                               |                                                                                           | 29c. License number<br><b>D25285</b>                                                                                                                                                                                                                                                                       |                                                                                                                                                      | 29d. Date signed (Month, Day, Year)<br><b>July 21, 2000</b>                                                                                                                                  |                                                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>W.A. Riley, BMC 6701 N. Charles St. Balto. Md 21212</b>                                                                                                                                                                                                                                                                        |                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                           | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                            |                                                                                                                                                      |                                                                                                                                                                                              |                                                       |

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State of Maryland / Department of Health and Mental Hygiene

00 23214

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES ROBERT NAYLOR</b>                         |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 2. Date of Death<br>Month Day Year<br><b>07 12 2000</b>                                                                                                                                      |                               | 3. Time of Death<br><b>5:35 AM</b>                                               |                                                                                                                                                                                                  |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b> |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>                                                                                                                                |                               | 4c. County of Death<br><b>BALTIMORE</b>                                          |                                                                                                                                                                                                  |                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>224228431</b>                                                    |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                                      | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                                                                                                                                             |                               | 8. Date of Birth (Month, Day, Year)<br><b>April 8, 1924</b>                      |                                                                                                                                                                                                  |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                      |  | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                     |                                                                                                                                      | 10b. County<br><b>Baltimore</b>                                                                                                                                                              |                               | 10c. City, Town or Location<br><b>Baltimore</b>                                  |                                                                                                                                                                                                  |                                   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                  |  |                                                                                                                                                                                                                                                                                             | 10e. Street and Number<br><b>8720 Emge Road</b>                                                                                      |                                                                                                                                                                                              | 10f. Zip Code<br><b>21234</b> |                                                                                  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>                                                                                                                               |                                                                                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                               |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                          |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unk</b><br>College (1-4 or 5+) <b>unk</b>                                                                                                                                                                                                                                                                                  |                                                                                                  |  |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>machine operator</b> |                                                                                                                                                                                              |                               | 16b. Kind of Business/Industry<br><b>unk</b>                                     |                                                                                                                                                                                                  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>unk</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unk</b>                                                                                                                              |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Good Samaritan Hospital</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5601 Loch Raven Blvd Baltimore, MD 21234</b>                                             |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state</b>                                                                                                                                                                        |                                                                                                  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                      |                                                                                                                                      | Date                                                                                                                                                                                         |                               | 20c. Location - City or Town, State                                              |                                                                                                                                                                                                  |                                   |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph B. Van Sant</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                                                                                   |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  | Approximate Interval Between Onset and Death                                                                                                                                                     |                                   |  |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  | 24 hours                                                                                                                                                                                         |                                   |  |
| a. <b>SEPSIS</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  | 2 - 3 d                                                                                                                                                                                          |                                   |  |
| b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  | yes                                                                                                                                                                                              |                                   |  |
| c. <b>DIABETES MELLITUS</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  | yes                                                                                                                                                                                              |                                   |  |
| d. <b>HTN</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  | yes                                                                                                                                                                                              |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>                                                                                                                                                                                                                                                                                    |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                  |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                      | 28b. Time of Injury<br>M                                                                                                                                                                     |                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |
| 29b. Signature and title of certifier<br><b>Sgt</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 29c. License number<br><b>D0053150</b>                                                                                                                                                       |                               | 29d. Date signed (Month, Day, Year)<br><b>07/12/2000</b>                         |                                                                                                                                                                                                  |                                   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>SHAKUNALA GUPTA M.D. GOOD SAMARITAN HOSPITAL</b>                                                                                                                                                                                                                                                                                  |                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |  | 32. Registrar's Signature<br><b>Sparks</b>                                                                                                                                                                                                                                                  |                                                                                                                                      |                                                                                                                                                                                              |                               |                                                                                  |                                                                                                                                                                                                  |                                   |  |

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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                     |                                                                                          |  |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                             |  |                                                            |                                                                                                                                                                                                                                                                                                         |                                                        |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><b>Claria Jane Prettyman</b>                 |  |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                               | 2. Date of Death<br>Month Day Year<br><b>July 18, 2000</b>  |  |                                                            |                                                                                                                                                                                                                                                                                                         | 3. Time of Death<br><b>1:08pm</b>                      |  |  |  |
|                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><b>4502 Coyle Road</b> |  |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>Owings Mills</b> |  |                                                            |                                                                                                                                                                                                                                                                                                         | 4c. County of Death<br><b>Baltimore</b>                |  |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                 | 5. Social Security Number<br><b>216-30-9732</b>                                          |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. Age (in yrs. last birthday)<br><b>70</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 1, 1930</b> |                                                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Md.</b> |  |  |  |
|                                                                                                                                                                                                                                                                                     | Usual Residence of Decedent                                                              |  |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                               | 10a. State<br><b>Md.</b>                                    |  |                                                            |                                                                                                                                                                                                                                                                                                         | 10b. County<br><b>Baltimore</b>                        |  |  |  |
| 10c. City, Town or Location<br><b>Owings Mills</b>                                                                                                                                                                                                                                  |                                                                                          |  |                                                                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                             |  |                                                            | 10e. Street and Number<br><b>4502 Coyle Road</b>                                                                                                                                                                                                                                                        |                                                        |  |  |  |
| 10f. Zip Code<br><b>21117</b>                                                                                                                                                                                                                                                       |                                                                                          |  |                                                                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                   |                                                             |  |                                                            | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                  |                                                        |  |  |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                          |                                                                                          |  |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |                                                             |  |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                 |                                                        |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th Grade</b> College (1-4 or 5+)                                                                                                                                                 |                                                                                          |  |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic/Waitress</b>                                                                                                                                                                                                                                                                                         |                                                             |  |                                                            | 16b. Kind of Business/Industry<br><b>Mercantile Country Club</b>                                                                                                                                                                                                                                        |                                                        |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Wesley Pollock, Jr.</b>                                                                                                                                                                                                          |                                                                                          |  |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Williams</b>                                                                                                                                                                                                                                                                                                                                                     |                                                             |  |                                                            | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon Moulton Daughter</b>                                                                                                                                                                                                                      |                                                        |  |  |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4502 Coyle Road Owings Mills, Md. 21117</b>                                                                                                                                     |                                                                                          |  |                                                                                | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |                                                             |  |                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forrest Veterans July 21</b>                                                                                                                                                                                      |                                                        |  |  |  |
| 20c. Location - City or Town, State<br><b>Owings Mills, Md.</b>                                                                                                                                                                                                                     |                                                                                          |  |                                                                                | 21. Signature of Funeral Service Licensee<br><b>Ernest R. Perry, Jr.</b>                                                                                                                                                                                                                                                                                                                                                      |                                                             |  |                                                            | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>                                                                                                                                                                                   |                                                        |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or chain of events.<br><b>a. Metastatic Non-small cell lung cancer</b>                  |                                                                                          |  |                                                                                | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |                                                             |  |                                                            | Approximate Interval Between Onset and Death<br><b>5 months</b>                                                                                                                                                                                                                                         |                                                        |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                          |                                                                                          |  |                                                                                | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |                                                             |  |                                                            | Due to (or as a consequence of):                                                                                                                                                                                                                                                                        |                                                        |  |  |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                    |                                                                                          |  |                                                                                | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |                                                             |  |                                                            | Due to (or as a consequence of):                                                                                                                                                                                                                                                                        |                                                        |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                              |                                                                                          |  |                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                      |                                                             |  |                                                            | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                               |                                                        |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                              |                                                                                          |  |                                                                                | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                             |  |                                                            | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                        |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |                                                                                          |  |                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                         |                                                             |  |                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                         |                                                        |  |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                |                                                                                          |  |                                                                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |  |                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                        |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                        |                                                                                          |  |                                                                                | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                             |  |                                                            | 29b. Signature and title of certifier<br><b>Julie R Brahmer, MD</b>                                                                                                                                                                                                                                     |                                                        |  |  |  |
| 29c. License number<br><b>00051770</b>                                                                                                                                                                                                                                              |                                                                                          |  |                                                                                | 29d. Date signed (Month, Day, Year)<br><b>July 20 2000</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                             |  |                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Julie R Brahmer, MD The Johns Hopkins Hospital, Baltimore, MD 21287</b>                                                                                                                                      |                                                        |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                             |                                                                                          |  |                                                                                | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                             |  |                                                            | State Registrar                                                                                                                                                                                                                                                                                         |                                                        |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23216

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1. Decedent's Name (First, Middle, Last)<br><b>HOWARD EUGENE PEREGOY</b>                             |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br><b>JULY 21, 2000</b> |                                                                                                                                                                                                          | 3. Time of Death<br><b>2:21 AM</b>                                                                 |                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b> |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>      |                                                                                                                                                                                                          | 4c. County of Death<br><b>BALTIMORE</b>                                                            |                                                                                                                                   |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 5. Social Security Number<br><b>220-24-5193</b>                                                      |                                                                                                                                                                                                                                                                                                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.                                                                                                                                                 | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>08/08/1930</b>                                           | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Usual Residence of Decedent                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      | 10b. County<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                         |                                                                            | 10c. City, Town or Location<br><b>PARKVILLE</b>                                                                                                                                                  |                                                            |                                                                                                                                                                                                          | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                   |
| 10e. Street and Number<br><b>7713 HILLSWAY AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            | 10f. Zip Code<br><b>21234</b>                                                                                                                                                                    |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                           |                                                                                                    |                                                                                                                                   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                     |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                     |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                            |                                                                                                                                                                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |                                                                                                                                   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH grade</b><br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FIRE CAPTAIN</b>                                                                 |                                                            |                                                                                                                                                                                                          | 16b. Kind of Business/Industry<br><b>COUNTY FIRE DEPT.</b>                                         |                                                                                                                                   |
| 17. Father's Name (First, Middle, Last)<br><b>ALFRED JACOB PEREGOY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ADA REMBOLD</b>                                                                                                                          |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JANET PEREGOY / WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7713 HILLSWAY AVE.; BALTIMORE, MD 21234</b>                                                  |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY CEMETERY</b>                                                                                         |                                                            | 20c. Location - City or Town, State<br><b>7/25 COCKEYSVILLE, MD</b>                                                                                                                                      |                                                                                                    |                                                                                                                                   |
| 21. Signature of Funeral Service Licensee<br><i>Heather N. Hupp</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.<br/>8521 LOCH RAVEN BLVD.; TOWSON, MD 21286</b>                                                                            |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>COPD</b><br>Due to (or as a consequence of):<br>c. <b>INTERSTITIAL LUNG DISEASE</b><br>Due to (or as a consequence of):<br>d. <b>RHEUMATOID ARTHRITIS</b> |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                                                                                                                          |                                                                                                    | Approximate Interval Between Onset and Death<br><b>6 MONTHS</b><br><b>&gt; 10 YRS</b><br><b>&gt; 10 YRS</b><br><b>&gt; 10 YRS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  |                                                            | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                                                    |                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  |                                                            | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                                                                    |                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                                                                    |                                                                                                                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                |                                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |                                                            | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                                                                    | 28d. Describe how injury occurred                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                  |                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                             |                                                                                                    |                                                                                                                                   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                             |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |
| 29b. Signature and title of certifier<br><i>Vincent A. DiPietro</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            | 29c. License number<br><b>D28812</b>                                                                                                                                                             |                                                            | 29d. Date signed (Month, Day, Year)<br><b>7/21/00</b>                                                                                                                                                    |                                                                                                    |                                                                                                                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VINCENT DIPIETRO, MD 7801 YORK ROAD SUITE 102 BALTIMORE, MD</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      | 32. Registrar's Signature<br><i>Benjamin B. Sparks</i>                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





FREDDIE POINDEXTER

State of Maryland / Department of Health and Mental Hygiene

00 23217

amend item 7,8 per fh G785 7/27/00 yg

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    |                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Freddie L. Poindexter</b>                             |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 19, 2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>0134 AM</b> |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4a. Facility Name (If not Institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL E.R.</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                                                                                                                                                                              | 4c. County of Death                |                                                                                                                                                                                                  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br><b>214-72-8310</b>                                                      | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.           | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.     | 8. Date of Birth (Month, Day, Year)<br><b>1957 05 16</b>                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 9. Birthplace (State or Foreign Country)<br><b>V.A.</b>                                              |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    |                                                                                                                                                                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                             |                                                            | 10c. City, Town or Location<br><b>Owings Mills</b>                                                                                                                                           |                                    | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |
| 10e. Street and Number<br><b>4519 Runnymede Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      | 10f. Zip Code<br><b>21117</b>                                                                                                                                                                                                                                                               |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |                                    |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                          |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                      | College (1-4or 5+) <b>Unk</b>                                                                                                                                                                                                                                                               |                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>                                                                    |                                    | 16b. Kind of Business/Industry<br><b>Post Office</b>                                                                                                                                             |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Poindexter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susie Sanford</b>                                                                                                                    |                                    |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robin Poindexter-Sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>203 Maiden Choice La., Baltimore Md 21228</b>                                            |                                    |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>                                                                                                                                                                                         |                                                            | Date<br><b>7/24/00</b>                                                                                                                                                                       |                                    | 20c. Location - City or Town, State<br><b>Randallstown, Md</b>                                                                                                                                   |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            | 22. Name and Address of Facility<br><b>March F/H West<br/>4300 Wabash Ave, Baltimore Md 21215</b>                                                                                            |                                    |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    | Approximate Interval Between Onset and Death                                                                                                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            |                                                                                                                                                                                              |                                    |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            | 28d. Describe how injury occurred                                                                                                                                                            |                                    |                                                                                                                                                                                                  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                            |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      | 29c. License number<br><b>O.C.M.E</b>                                                                                                                                                                                                                                                       |                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 19, 2000</b>                                                                                                                                  |                                    |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                    |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                            |                                                                                                                                                                                              |                                    |                                                                                                                                                                                                  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 23218

AMEND#31 PER DVR G785 7-24-2000 JAB

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH PEAKS

2. Date of Death

07 21 2000

3. Time of Death

6:55 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

OLD COURT NURSING CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

217 30 2967

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 8, 1899

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

261 ROBERT STREET

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

FOOD

17. Father's Name (First, Middle, Last)

MARSHALL SMALLWOOD

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

19a. Informant's Name/Relationship (Type, Print)

ANNE STANCIL/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2020 FEATHERBED LANE, BALTO., MD. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN

Date

7/26/2000

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON &amp; SONS F.H, INC

1701 LAURENS ST., BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

James A. Morton

29c. License number

D0020964

29d. Date signed (Month, Day, Year)

07/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Liberty Plaza Mall Randallstown MD 21133

31. Date filed (Month, Day, Year)

07/24/00 JUL 24 2000

32. Registrar's Signature

Benita B Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

8630

State  
Registrar

20) 0.112 18' 5"  
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GM m 1.00000000

21) 0.112 18' 5"  
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22) 0.112 18' 5"  
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23) 0.112 18' 5"  
Saturated. m' 1.00000000  
GM m 1.00000000

00 23219

## Reg. No.

DMMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 23220

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

|                                                                                           |  |                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                |  |                                                                                                                                                   |  |
|-------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>NEAL JAY ROBERTS</b>                       |  |                                                                                                                                                                                                                                                            |  | 2. Date of Death<br>Month Day Year<br><b>JULY 18, 2000</b>                                                                                                                     |  | 3. Time of Death<br><b>3:46 PM</b>                                                                                                                |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>771 220TH STREET</b> |  |                                                                                                                                                                                                                                                            |  | 4b. City, Town, or Location of Death<br><b>PASADENA</b>                                                                                                                        |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>                                                                                                        |  |
| 5. Social Security Number<br><b>219-40-9077</b>                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                 |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.                                                                                                                               |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 29, 1943</b>                                                                                      |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                               |  | 10. Usual Residence of Decedent<br>10a. State<br><b>MARYLAND</b><br>10b. County<br><b>ANNE ARUNDEL</b><br>10c. City, Town or Location<br><b>PASADENA</b><br>10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |

Funeral  
Director

To Be Completed by Funeral Director

|                                                                                                                                                    |  |                                                                                                                                                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:           |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                               |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SUPERVISOR</b>                                                                                                        |  |
| 16b. Kind of Business/Industry<br><b>WAREHOUSE</b>                                                                                                 |  | 17. Father's Name (First, Middle, Last)<br><b>WESLEY S. ROBERTS</b>                                                                                                                                                                   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>THELMA FURHMAN</b>                                                                         |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. DIANE M. ROBERTS (WIFE)</b>                                                                                                                                               |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>771 220TH STREET, PASADENA, MARYLAND 21122</b> |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>                                               |  | 20c. Location - City or Town, State<br><b>BROOKLYN PARK, MD.</b>                                                                                                                                                                      |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                      |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                                                                                                            |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Liver FAILURE</b><br>Due to (or as a consequence of):<br><b>b. RIVER METASTASES</b><br>Due to (or as a consequence of):<br><b>c. ESOPHAGEAL ADENOCARCINOMA</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>2 W</b><br><b>4 M</b><br><b>2 Y</b> |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|

|                                                                                                                        |  |                                                                                                                                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                                                                                                        |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                                                                                                        |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |  |

|                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                          |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><b>7/19/00</b>                                                                                                                                                                                                                                     |  |
| 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                            |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                            |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                          |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Dr. Hausner, MD, PhD</b> |  |
| 29c. License number<br><b>D48160</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. Date signed (Month, Day, Year)<br><b>7/19/00</b>                |  |

|                                                                                                                                                               |  |                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PETR HAUSNER, MD, PhD, 22 South Greene Str. Baltimore MD 21201</b> |  | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b> |  |
| 32. Registrar's Signature<br>                                                                                                                                 |  |                                                         |  |

State  
Registrar

NEIL ROBERTS  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-342-2024.



2183012  
HEIL FORBES

W. J. 3801117 10/11  
M. A. 2501117 10/11  
15 1111111 10/11 10/11

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State of Maryland / Department of Health and Mental Hygiene 00 23221

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                  |  |                                                                                             |  |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Rdand Francis Riesett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>2000</b>                                                                                                                             |  | 3. Time of Death<br><b>14:00</b>                                                            |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                                                                                                                                        |  | 4c. County of Death<br><b>Allegany</b>                                                      |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-20-4412</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.                                                                                                                                                 |  | 8. Date of Birth (Month, Day, Year)<br><b>JANUARY 24, 1929</b>                              |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                               |  | 10b. County<br><b>GARRETT</b>                                                                                                                                                                    |  | 10c. City, Town or Location<br><b>LONA CONING</b>                                           |  |
| To Be Completed by Funeral Director           | 10a. Street and Number<br><b>172 LAURELWOOD DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>21539</b>                                                                                                                                                                    |  | 10g. Citizen of What Country?<br><b>UNITED STATES OF AMERICA</b>                            |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH GRADE</b> College (14 or 5+) <b>NONE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SUPERVISOR CHECK DIVISION</b>                                                    |  | 16b. Kind of Business/Industry<br><b>BANKING</b>                                            |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>EDGAR RIESETT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EDNA BEHRENS</b>                                                                                                                         |  |                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>EMOGENE RIESETT / WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>172 LAURELWOOD DRIVE / LONA CONING, MD. 21539</b>                                            |  |                                                                                             |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY</b>                                                                                                                                                                                          |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                |  | 20d. Date<br><b>JUN 24, 2000</b>                                                            |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Donald R. Watson, Jr. MO0612</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>ALTENBURG FUNERAL HOME, P.A. BALTIMORE, MD. 21214</b>                                                                                                     |  |                                                                                             |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>intracerebral hemorrhage</b><br>Due to (or as a consequence of):<br>b. <b>metastatic cancer to brain</b><br>Due to (or as a consequence of):<br>c. <b>carcinoma of colon with metastasis widespread</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                             |  | Approximate Interval Between Onset and Death<br><br><b>4 days</b><br><br><b>1 month</b><br><br><b>6 months</b>                                                                                   |  |                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |                                                                                             |  |
|                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                  |  |                                                                                             |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |  |                                                                                             |  |
|                                               | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                  |  |                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Donald R. Watson, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 29c. License number<br><b>009831</b>                                                                                                                                                                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>7-19-00</b>                                                                                                                                            |  |                                                                                             |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DONALD MANGER 11600 Bedford Road Cumberland Md 21502</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                  |  |                                                                                             |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                  |  |                                                                                             |  |

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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>William Anthony Melcavage</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 22, 2000</b>                                                                                                                                   |                                                                                             | 3. Time of Death<br><b>9:20 AM</b>                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>1646 Wall Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              | 4b. City, Town, or Location of Death<br><b>Pasadena</b>                                                                                                                                      |                                                                                             | 4c. County of Death<br><b>Anne Arundel</b>                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>164-18-0544</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                                                              | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                                                                                                                                             |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>Oct 7, 1920</b>               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>Maryland</b>                                                                                                                     |                                                                              | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                           |                                                                                             | 10c. City, Town or Location<br><b>Pasadena</b>                          |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             | 10e. Street and Number<br><b>1646 Wall Drive</b>                                                                                                  |                                                                              | 10f. Zip Code<br><b>21122</b>                                                                                                                                                                |                                                                                             | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b>                     |                                                                              | 16b. Kind of Business/Industry<br><b>General Electric</b>                                                                                                                                    |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>Joseph Melcavage</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Mojouskas</b>                                                                                                                |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph A. Melcavage / son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1646 Wall Drive, Pasadena, Maryland 21122</b>                                            |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Park</b>                                            |                                                                              | 20c. Location - City or Town, State<br><b>7/26/2000 Elkridge, Maryland</b>                                                                                                                   |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              | 22. Name and Address of Facility<br><b>Hubbard Funeral Home, Inc.<br/>4107 Wilkens Avenue, Baltimore, Maryland 21229</b>                                                                     |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Colon Carcinoma</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              |                                                                                                                                                                                              |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              |                                                                                                                                                                                              |                                                                                             |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                           |                                                                                             |                                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              |                                                                                                                                                                                              |                                                                                             |                                                                         |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                              |                                                                                                                                                                                              |                                                                                             |                                                                         |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                              |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                              |                                                                                             |                                                                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              |                                                                                                                                                                                              |                                                                                             |                                                                         |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 29c. License number<br><b>031551</b>                                         |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>July 24, 2000</b>                                 |                                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Russell Q. Delaney, 1600 S. Gain Highway, Glen Burnie, Md. 21061</b>                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                              |                                                                                                                                                                                              |                                                                                             |                                                                         |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                                                                                                   |                                                                              |                                                                                                                                                                                              |                                                                                             |                                                                         |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

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| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>ANNETTE MARTHA SHANKLIN</b>                           |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                     | 2. Date of Death<br>Month Day Year<br><b>JULY 23, 2000</b> |                                                                                                                                                        | 3. Time of Death<br><b>12:10 PM</b>                         |                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b> |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                     | 4b. City, Town, or Location of Death<br><b>Towson</b>      |                                                                                                                                                        | 4c. County of Death<br><b>Baltimore</b>                     |                                                                            |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>218-32-7315</b>                                                      |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                     | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.           |                                                                                                                                                        | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 22, 1937</b> |                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Md.</b>                                    |                                                                                                                                                                                                                                                                                                         | 10a. State<br><b>Md.</b>                                                       |                                                                                                                                                                                                                                                                                     | 10b. County<br><b>Carroll</b>                              |                                                                                                                                                        | 10c. City, Town or Location<br><b>Westminster</b>           |                                                                            |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                      |                                                                                | 10e. Street and Number<br><b>209 Singletree Ct.</b>                                                                                                                                                                                                                                 |                                                            | 10f. Zip Code<br><b>21157</b>                                                                                                                          |                                                             | 10g. Citizen of What Country?<br><b>U.S.A.</b>                             |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                       |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                   |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                |                                                             |                                                                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                 |                                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                                                                                                                           |                                                                                | 16b. Kind of Business/Industry<br><b>Homemaking</b>                                                                                                                                                                                                                                 |                                                            | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>                                                                                              |                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Viola Campbell</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Eugene M. Shanklin - husband</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>209 Singletree Ct. Westminster, Md. 21157</b>                                                                                                                                                       |                                                                                | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                     |                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Vet. Cemetery July 27, 2000 Owings Mills, Md.</b>                |                                                             | 20c. Location - City or Town, State                                        |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                              |                                                                                                      | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel</b><br><b>11605 Reisterstown Rd. Owings Mills, Md. 21117</b>                                                                                                                                                                             |                                                                                | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.<br><b>CORONARY ARTERY DISEASE</b>                                                |                                                            | 23b. Approximate Interval Between Onset and Death<br><b>YEARS</b>                                                                                      |                                                             |                                                                            |  |
| 23a. Part II: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.<br><b>PERIPHERAL VASCULAR DISEASE</b>                                                                                                                                                                                    |                                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                     |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                           |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                             |                                                                            |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                        |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                 |                                                             | 28b. Time of Injury<br><b>M</b>                                            |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |                                                                                                      | 28b. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                         |                                                                                | 28c. Describe how injury occurred                                                                                                                                                                                                                                                   |                                                            | 28d. Location (Street and Number or Rural Route Number, City or Town, State)                                                                           |                                                             |                                                                            |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                      | 29b. Signature and title of certifier<br>                                                                                                                                                                            |                                                                                | 29c. License number<br><b>D 31826</b>                                                                                                                                                                                                                                               |                                                            | 29d. Date signed (Month, Day, Year)<br><b>7-23-2000</b>                                                                                                |                                                             |                                                                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RICHARD L. LINTHICUM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>                                                                                                                                                                                                                                                          |                                                                                                      | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                 |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                   |                                                            |                                                                                                                                                        |                                                             |                                                                            |  |

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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• *Journal of Management Inquiry* 236

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Involvement in 2002

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THE UNIVERSITY OF CHICAGO



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23224

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>Henry Solomon</b>                            |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>2000</b>                                                                                                                         |                                                                                |                                |                                                                                  | 3. Time of Death<br><b>6:40am</b>                                       |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4e. Facility Name (If not institution, give street and number)<br><b>Genesis Elder Care</b> |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Brooklyn</b>                                                                                                                                      |                                                                                |                                |                                                                                  | 4c. County of Death<br><b>Anne Arundel</b>                              |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>212-42-5300</b>                                             |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F<br><b>XX</b>                                                           |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.                                                                                                                                             |                                                                                | If Under 1 Year<br>Months Days |                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>10-27-31</b>                  |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Usual Residence of Decedent                                                                 |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             | 10b. County<br><b>NA</b> |                                                                                                                                                   | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                                       |                                                                                                                                         |  |
| 10e. Street and Number<br><b>2621 E. Monument Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                          |                                                                                                                                                   | 10f. Zip Code<br><b>21205</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                              |                                                                                |                                | 10g. Citizen of What Country?<br><b>USA</b>                                      |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                |                                |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4th Grade</b><br>College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                          |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>                                                                                                                                                                 |                                                                                                                                                                                              |                                                                                |                                | 16b. Kind of Business/Industry<br><b>Contract worker</b>                         |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 17. Father's Name (First, Middle, Last)<br><b>Arthur Solomon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice Whitfield</b> |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce Ann Pridgett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                          |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1006 N. Durham Street Baltimore, Maryland 21205</b>                                                                                                                                     |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                          |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Voshell Mem. Gardens</b>                                                                                                                                                                                       |                                                                                                                                                                                              |                                                                                |                                | Date<br><b>07-25-2000</b>                                                        |                                                                         | 20c. Location - City or Town, State<br><b>Dundalk, MD.</b>                                                                                                                                       |                                                       |                                                                                                                                         |  |
| 21. Signature of Funeral Service Licensee<br><b>Gabriele Cook</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |                          |                                                                                                                                                   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C. March FH 1101 E. North Avenue</b>                                                                                                                                                                          |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Stomach Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><br><b>c. _____</b><br>Due to (or as a consequence of):<br><br><b>d. _____</b> |                                                                                             |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         | Approximate Interval Between Onset and Death<br><b>1 year</b>                                                                                                                                    |                                                       |                                                                                                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                       |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |                          |                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                          |                                                                                                                                                   | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                                                              | 28b. Time of Injury<br><b>M</b>                                                |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                                                                                                                                |                                                       |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                          |                                                                                                                                                   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                                                              |                                                                                |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                              |                                                                                             |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 29b. Signature and title of certifier<br><b>P. H. _____ MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                          |                                                                                                                                                   | 29c. License number<br><b>D53462</b>                                                                                                                                                                                                                                                        |                                                                                                                                                                                              |                                                                                |                                | 29d. Date signed (Month, Day, Year)<br><b>7/21/00</b>                            |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jude Muneses, MD 7845 Oakwood Road Glen Burnie MD 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             |                          |                                                                                                                                                   | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                                                                                         |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



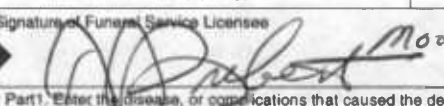
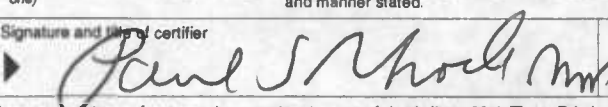

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23225

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>MARION JOSEPH STOLARSKI</b>                              |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 21, 2000</b>  |                                                                                                                                                                                              | 3. Time of Death<br><b>4:20 AM</b>         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>Annapolitan Genesis Elder Care</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Annapolis</b>    |                                                                                                                                                                                              | 4c. County of Death<br><b>Anne Arundel</b> |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>213-07-3506</b>                                                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.            | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. Date of Birth (Month, Day, Year)<br><b>August 15, 1912</b>                                           |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |                                                                                                                                                                                              |                                            |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |                                            |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                          |                                                             | 10c. City, Town or Location<br><b>Glen Burnie</b>                                                                                                                                            |                                            |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |                                            |
| 10e. Street and Number<br><b>717 Marlboro Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         | 10f. Zip Code<br><b>21061</b>                                                                                                                                                                                                                                                               |                                                             | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |                                            |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                            |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |                                            |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b>                                                                                                                                                               |                                                             | 16b. Kind of Business/Industry<br><b>Bethlehem Steel</b>                                                                                                                                     |                                            |
| 17. Father's Name (First, Middle, Last)<br><b>Antoni Stolarski</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Dembrowski</b>                                                                                                                                                                                                                |                                                             |                                                                                                                                                                                              |                                            |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Dolores Stavely</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>711 James Road, Glen Burnie, Maryland 21061</b>                                                                                                                                         |                                                             |                                                                                                                                                                                              |                                            |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>                                                                                                                                                                                        |                                                             | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                            |                                            |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                                                                                                                                                                  |                                                             |                                                                                                                                                                                              |                                            |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. End stage Dementia</b><br>Due to (or as a consequence of):<br><b>b. Multiple Infarcts, Cerebral</b><br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. {<br>Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                         | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                             |                                                                                                                                                                                              |                                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                             |                                                                                                                                                                                              |                                            |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |                                                             |                                                                                                                                                                                              |                                            |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                             |                                                                                                                                                                                              |                                            |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                            |                                                                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                             | 28b. Time of Injury<br>M                                                                                                                                                                     |                                            |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                       |                                            |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |                                            |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                          |                                                                                                         | 29b. Signature and title of certifier<br>                                                                                                                                                                |                                                             | 29c. License number<br><b>D22028</b>                                                                                                                                                         |                                            |
| 29d. Date signed (Month, Day, Year)<br><b>7-21-00</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |                                            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. PAUL S. RHODES, M.D., CROFTON MEDICAL GROUP, 1667 CROFTON CENTRE, CROFTON, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | <b>21114</b>                                                                                                                                                                                                                                                                                |                                                             |                                                                                                                                                                                              |                                            |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         | 32. Registrar's Signature<br>                                                                                                                                                                            |                                                             |                                                                                                                                                                                              |                                            |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-387-0000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



State of Maryland / Department of Health and Mental Hygiene  
F.H. - G785 7-20-00, WR. 00 23226  
7-21-00  
*Certificate of Death*  
Reg. No.

AMEND ITEMS: #10A-F PER F.H. 7-21-00  
21 PER F.H. 7-21-00

Reg. No.

**Division of Vital Records, P.O. Box 68760,**





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23227

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                   |                                |                                                                                                                                                                                                                                                                                             |                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br><u>William Streets</u>                                        |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2. Date of Death<br>Month <u>July</u> Day <u>19</u> Year <u>2000</u> |                                                                                                                   |                                |                                                                                                                                                                                                                                                                                             | 3. Time of Death<br><u>8:09 AM</u>             |  |
|                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br><u>Veterans Administration Hospital</u> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><u>Baltimore</u>             |                                                                                                                   |                                |                                                                                                                                                                                                                                                                                             | 4c. County of Death                            |  |
| Funeral<br>Director                                                                                                                                                                                                                                                        | 5. Social Security Number<br><u>216-24-1254</u>                                                           |                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><u>69</u> Yrs.                     |                                                                                                                   | If Under 1 Year<br>Months Days |                                                                                                                                                                                                                                                                                             | If Under 24 Hrs.<br>Hours Min.                 |  |
|                                                                                                                                                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br><u>7-27-1930</u>                                                   |                                                                                                                                                   | 9. Birthplace (State or Foreign Country)<br><u>Md</u>                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10a. State<br><u>Md</u>                                              |                                                                                                                   | 10b. County<br><u>Balto</u>    |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><u>Woodlawn</u> |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                             |                                                                                                           | 10e. Street and Number<br><u>2101 Meadowview Drive</u>                                                                                            |                                                                            | 10f. Zip Code<br><u>21207</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                      | 10g. Citizen of What Country?<br><u>U S A</u>                                                                     |                                |                                                                                                                                                                                                                                                                                             |                                                |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                             |                                                                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                                           |                                |                                                                                                                                                                                                                                                                                             |                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12th grade</u><br>College (1-4 or 5+) <u>B A Degree</u>                                                                                                                  |                                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Security Officer</u>              |                                                                            | 16b. Kind of Business/Industry<br><u>Social Security Administration</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                      | 17. Father's Name (First, Middle, Last)<br><u>William Street</u>                                                  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Queenie Brown</u>                                                                                                                                                                                                                   |                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Brenda Streets- Wife</u>                                                                                                                                                                                            |                                                                                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2101 Meadowview Drive Woodlawn, Md 21207</u>  |                                                                            | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                         |                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Garrison Forest Veteran 7-27-00</u>  |                                | 20c. Location - City or Town, State<br><u>Owings Mills, Md</u>                                                                                                                                                                                                                              |                                                |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                                                                                                                                                                                            |                                                                                                           | 22. Name and Address of Facility<br><u>March F/H West</u><br><u>4300 Wabash Avenue Baltimore, Md 21215</u>                                        |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <u>Sepsis</u><br>Due to (or as a consequence of):<br><br>b. <u>Aspiration Pneumonia</u><br>Due to (or as a consequence of):<br><br>c. <u>Bowel ischemia versus infarction</u><br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                      | Approximate Interval Between Onset and Death                                                                      |                                |                                                                                                                                                                                                                                                                                             |                                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                           |                                                                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                             |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                      | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                                                                           | 28a. Date of Injury (Month, Day Year)                                                                                                             |                                                                            | 28b. Time of Injury<br><u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                       |                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                     |                                                                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                                            | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                  |                                                                      | 29b. Signature and title of certifier<br><u>[Signature]</u>                                                       |                                | 29c. License number<br><u>P12411</u>                                                                                                                                                                                                                                                        |                                                |  |
| 29d. Date signed (Month, Day, Year)<br><u>July 19 2000</u>                                                                                                                                                                                                                 |                                                                                                           | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Jeff Hill 10 N. Green Street Baltimore M.D. 21201</u>  |                                                                            | 31. Data filed (Month, Day, Year)<br><u>JUL 24 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                      | 32. Registrar's Signature<br><u>[Signature]</u>                                                                   |                                |                                                                                                                                                                                                                                                                                             |                                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 19B PER F.H. G785 7-24-00 <sup>MD</sup> ~~WB~~   
 State of Maryland / Department of Health and Mental Hygiene

00 23228

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  |                                                                                                                                                                                                       |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>Araron William Segal</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>2000</b>                                                                                                                                  |                                                                                      | 3. Time of Death<br><b>3:55 pm</b>                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>GEE Randallstown</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>                                                                                                                                           |                                                                                      | 4c. County of Death<br><b>Baltimore County</b>                                                 |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>213-18-1940</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                        | If Under 24 Hrs.<br>Hours Min.                                                       | 8. Date of Birth (Month, Day, Year)<br><b>4-29-20</b>                                          | 9. Birthplace (State or Foreign Country)<br><b>D.C.</b>                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  |                                                                                                                                                                                                       |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 10b. County<br><b>NA</b>                                                                                                                          |                                                  | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                       |                                                                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br><b>3119 Cresson Ave</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  | 10f. Zip Code<br><b>21244</b>                                                                                                                                                                         |                                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                 |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:      |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th grade</b> College (1-4or 5+) <b>na</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>                       |                                                  | 16b. Kind of Business/Industry<br><b>G.S.A. Company</b>                                                                                                                                               |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br><b>Ben Segal</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>                                                                                                                                   |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine Carter-Sister</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3107 ST. LUKES LANE BALTIMORE, MD 21207</b><br><del>3107 St. Lukes Lane, Baltimore Md 21207</del> |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet 7/24/00</b>                                      |                                                  | 20c. Location - City or Town, State<br><b>Owings Mills, Md</b>                                                                                                                                        |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br><b>William Edmond</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore Md 21215</b>                                                                                               |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>SEPSIS</b><br>a. Due to (or as a consequence of):<br><br><b>SCHIZOPHRENIA; DEAFNESS;</b><br><b>BLINDNESS; ANEMIA</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  |                                                                                                                                                                                                       |                                                                                      |                                                                                                | Approximate Interval Between Onset and Death<br><b>1 DAY</b>                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SCHIZOPHRENIA; DEAFNESS;</b><br><b>BLINDNESS; ANEMIA</b>                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  |                                                                                                                                                                                                       |                                                                                      |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                  |                                                                                                                                                                                                       |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                  |                                                                                                                                                                                                       | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                                                                                                                                                                        |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 29b. Signature and title of certifier<br><b>W. Edmond</b>                                                                                                                                                                                                                                               |                                                                                                                                                   | 29c. License number<br><b>DS2360</b>             |                                                                                                                                                                                                       | 29d. Date signed (Month, Day, Year)<br><b>7/20/00</b>                                |                                                                                                |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ICULBIR SANDHU 1838 CREEK TREE RD, SUITE 300 Pikesville MD 21208</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  |                                                                                                                                                                                                       |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                  |                                                                                                                                                                                                       |                                                                                      |                                                                                                |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23229

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELMER F. SONNENLEITER

2. Date of Death

Month  
JULY

Day

20, 2000

Year

3. Time of Death

2:20 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GENESIS ELDER CARE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

216-07-1408A

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year  
JUNE 06, 1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2914 HOLLINS FERRY ROAD

10f. Zip Code

21230

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

STEEL COMPANY

17. Father's Name (First, Middle, Last)

HENRY SONNENLEITER

18. Mother's Name (First, Middle, Maiden Surname)

MARY BECKMAN

19a. Informant's Name/Relationship (Type, Print)

JON SONNENLEITER-SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2914 HOLLINS FERRY ROAD, BALTIMORE, MARYLAND 21230

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FORT LINCOLN CREMATORY

Date

07-21-00

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

LOUDON PARK FUNERAL HOME  
3620 WILKENS AVENUE, BALTIMORE, MARYLAND 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Coronary Vascular Accident*  
Due to (or as a consequence of):b.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

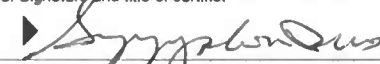
M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D40491

29d. Date signed (Month, Day, Year)

07-21-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

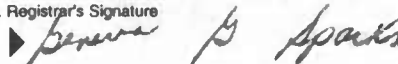
NED M. A. RITZ 800 NORTH HAMMOND FERRY Rd LINTICUM 21090

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature



ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2022.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23230

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DINETTA L. SHROPSHIRE

2. Date of Death

July 17 2000

3. Time of Death

4:20

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE AT MERCY

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

219-66-5421

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7-5-1957

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

249 AISQUITH ST.

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CITY EMPLOYEE

16b. Kind of Business/Industry

BALTIMORE CITY

17. Father's Name (First, Middle, Last)

GEORGE SHROPSHIRE

18. Mother's Name (First, Middle, Maiden Surname)

ETTA SHROPSHIRE

19a. Informant's Name/Relationship (Type, Print)

LEONA LINCOLN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1648 CHILTON ST. BALTO., MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

7-21-2000

20c. Location - City or Town, State

CATONSVILLE MD

21. Signature of Funeral Service Licensee

EUGENE WALKER

22. Name and Address of Facility

ESTEP BROS. FUNERAL SERVICE

1300 EUTAW PLACE BALTO. MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Leomyosarcoma  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D40854

29d. Date signed (Month, Day, Year)

July 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

00 23231

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Smith

2. Date of Death

Month

Day

Year

07 16 2000

3. Time of Death

12:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Millennium of Liberty Hqts. 4017 Liberty Hts.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

215-40 3328

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09-3-1942

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4017 Liberty Heights Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

Carlos Smith

18. Mother's Name (First, Middle, Maiden Surname)

Annie Smith

19a. Informant's Name/Relationship (Type, Print)

Sharon Gunn/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6706 Chisholm Drive Baltimore, MD 21207

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE HUMAN IMMUNODEFICIENCY

Due to (or as a consequence of):

2 WEEKS

b. VIRUS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. END STAGE RENAL DISEASE

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deborah I. Pierce

29c. License number

H45931

29d. Date signed (Month, Day, Year)

JULY 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah I. Pierce

7220 Park Heights Avenue Baltimore, MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Deborah I. Pierce

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23232

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5026.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARY NETTIE STOKES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>2000</b>                                                                               |                                | 3. Time of Death<br><b>13:15</b>                                                                                                                                                                |
| 4a. Facility Name (If not institution, give street and number)<br><b>SCU FALLSTON GENERAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 4b. City, Town, or Location of Death<br><b>FALLSTON</b>                                                                                            |                                | 4c. County of Death<br><b>HARFORD</b>                                                                                                                                                           |
| 5. Social Security Number<br><b>213-26-0991</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.                                                                                                   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                  |
| 8. Date of Birth (Month, Day, Year)<br><b>MAY 14 1929</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b>                                                                                  |                                |                                                                                                                                                                                                 |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 10b. County<br><b>HARFORD</b>                                              | 10c. City, Town or Location<br><b>JOPPA</b>                                                                                                        |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                  |
| 10e. Street and Number<br><b>1409 MANDEVILLE ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 10f. Zip Code<br><b>21085</b>                                                                                                                      |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3rd grade</b><br>College (1-4 or 5+) <b>COOK</b> |                                |                                                                                                                                                                                                 |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOOD SERVICE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 16b. Kind of Business/Industry                                                                                                                     |                                |                                                                                                                                                                                                 |
| 17. Father's Name (First, Middle, Last)<br><b>CHALMUS BROADNAX</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARTHA LEMMONS</b>                                                                         |                                |                                                                                                                                                                                                 |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sandra Hawthorne/Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1409 Mandeville Rd., Joppa Md., 21085</b>      |                                |                                                                                                                                                                                                 |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>COMMUNITY BAPTIST CHURCH</b>                                          |                                | 20c. Location - City or Town, State<br><b>JOPPA, MARYLAND</b>                                                                                                                                   |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | 22. Name and Address of Facility<br><b>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA<br/>321 S PHILADELPHIA BLVD, ABERDEEN, MARYLAND</b>               |                                |                                                                                                                                                                                                 |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASCVD</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                             |                                | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                 |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 28d. Describe how injury occurred                                                                                                                  |                                |                                                                                                                                                                                                 |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                       |                                |                                                                                                                                                                                                 |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 29b. Signature and title of certifier<br> <b>OME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 29c. License number<br><b>OCME</b>                                                                                                                 |                                | 29d. Date signed (Month, Day, Year)<br><b>July 20, 2000</b>                                                                                                                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GRACIE M.D. 728 BRAN MD BRAN MD 21014</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                    |                                |                                                                                                                                                                                                 |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 32. Registrar's Signature<br>                                   |                                |                                                                                                                                                                                                 |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23233

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Steve Michael Solomon

2. Date of Death

Month

Day

Year

July 22, 2000

3. Time of Death

4:02 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

217-09-4239

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 18, 1917

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3822 Proctor Lane

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Peacetime

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office worker

16b. Kind of Business/Industry

Beth Steel

17. Father's Name (First, Middle, Last)

Michael Solomonides

18. Mother's Name (First, Middle, Maiden Surname)

Eleanora Zartaloudes

19e. Informant's Name/Relationship (Type, Print)

Ann Solomon - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3822 Proctor Lane Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greek Cemetery

Date

7/25/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Paul L. Hartoch, Jr.

22. Name and Address of Facility

Baltimore, Maryland 21214  
Leonard J. Ruck, Inc. 5305 Harford Rd.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Melanoma status Post Excision

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yvonne Latimer MD

29c. License number

RD 203471

29d. Date signed (Month, Day, Year)

07/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yvonne Latimer, MD 9000 Franklin Square Drive, Baltimore MD, 21237

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Geneva G Sparks

ORIGINAL

Stephen Solomon

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





00-4011-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ANGELA

State of Maryland / Department of Health and Mental Hygiene

SLEEMAN

AMEND ITEMS: #23 PART I, 11, 27

Certificate of Death

Reg. No.

00 23234

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                            |  |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Angela Mary SLEEMAN</b>                                                                                                                                                                                                     |  |                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 20, 2000</b> |                                                                                                                                                                                              |                                                            |                                                                                             | 3. Time of Death<br><b>3:33P.M.</b>                                                                                                                                                              |                                                                         |                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                                                                           |  |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                                                                                                                                                                              |                                                            |                                                                                             | 4c. County of Death                                                                                                                                                                              |                                                                         |                                                                                                |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>220-10-7529</b>                                                                                                                                                                                                                            |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.           |                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>May 22, 1917</b> |                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Cumberland, MD</b>                                                                                                                                |                                                                         |                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                    |  |                                                                            |                                                                                                                                                                                                                                                                                             | 10b. County<br><b>--</b>                                   |                                                                                                                                                                                              |                                                            |                                                                                             | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                  |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><b>820 Cator Avenue</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                            |  |                                                                            | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                                                                                                               |                                                            |                                                                                                                                                                                              |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                            |  |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                            |                                                                                             |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4or 5+)                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                            |  |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                                                                                                               |                                                            |                                                                                                                                                                                              |                                                            | 16b. Kind of Business/Industry<br><b>Own home</b>                                           |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| 17. Father's Name (First, Middle, Last)<br><b>John Kienhofer</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                            |  |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Kelly</b>                                                                                                                                                                                                                    |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas J. Sleeman - Son</b>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                            |  |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>820 Cator Ave., Baltimore, MD 21218</b>                                                                                                                                                 |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                                                                                                                                                                                            |  |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Mem'l Park</b>                                                                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                                            | 20c. Location - City or Town, State<br><b>7/25/00 Cumberland, MD</b>                        |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| 21. Signature of Funeral Service Licensee<br> <b>William G. Dau</b>                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                            |  |                                                                            | 22. Name and Address of Facility<br><b>Leonard J. Ruck Funeral Home, Inc.<br/>5305 Harford Rd., Baltimore, MD 21214</b>                                                                                                                                                                     |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PULMONARY THROMBO-EMBOLISM DUE TO DEEP VEIN THROMBOSIS</b> |  |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             | Approximate Interval Between Onset and Death                                                                                                                                                     |                                                                         |                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>                                                                                               |  |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                         |                                                                                                |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                            |  |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                            |  |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                           |                                                                                                                                                                                                                                                                            |  |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  | 28d. Describe how injury occurred                                       |                                                                                                |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                            |  |                                                                            | 29b. Signature and title of certifier<br> <b>Dennis Chuter</b>                                                                                                                                           |                                                            |                                                                                                                                                                                              |                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                      |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br><b>JULY 21, 2000</b>             |                                                                                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis Chuter</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                            |  |                                                                            | 31. Data filed (Month, Day, Year)<br><b>AUG 24 2000</b>                                                                                                                                                                                                                                     |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                            |  |                                                                            | 33. Registrar's Signature<br>                                                                                                                                                                            |                                                            |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23235

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NAOMI SOLLARS

2. Date of Death

JULY 18 2000

3. Time of Death

3:50 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

216-36-9292

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAR. 17, 1902

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6101 16TH STREET, N.W. #601

10f. Zip Code

20011

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

MD DEPT OF MOTOR VEH.

17. Father's Name (First, Middle, Last)

JACOB

18. Mother's Name (First, Middle, Maiden Surname)

FINK

BESSIE

HYMAN

19a. Informant's Name/Relationship (Type, Print)

SHAWN SPRINGER / ATTORNEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12818 LACY DRIVE - SILVER SPRING, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BNAI ISRAEL CEMETERY

Date

7/21/00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EDEMA

Due to (or as a consequence of):

b. AORTIC STENOSIS

Due to (or as a consequence of):

c. PNEUMONIA

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] K.S. RAO, M.D.

29c. License number

043462

29d. Date signed (Month, Day, Year)

JULY 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.S. RAO, M.D.  
NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2024.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23236

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCIS

SPALDING

2. Date of Death

Month Day Year  
July 20 2000

3. Time of Death

5:30pm

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN

HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

214-03-5526

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
December 9, 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

--

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3107 Beverly Road

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Expeditor

16b. Kind of Business/Industry

Steel Company

17. Father's Name (First, Middle, Last)

Bernard William Spalding, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Etta Schulz Norton

19a. Informant's Name/Relationship (Type, Print)

Ronald N. Spalding- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3120 Woodring Ave., Baltimore, MD 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem'l Gard. 7/24/00 Timonium, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William G. Dau

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.  
5305 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia, nosocomial.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

Cerebro vascular disease.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

MD

29c. License number

P13453

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GONZALO GRANIELLA MD. / 5601 Loch Raven Blvd, Baltimore MD 21239

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23237

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Washington Turner

2. Date of Death

07 22 2000

3. Time of Death

1:30 A.M.

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital 5015 Union Ave.

4b. City, Town, or Location of Death

Havre DeGrace

4c. County of Death

Harford County

Funeral  
Director

5. Social Security Number

705-09-7397

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02-22-1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Harford

10c. City, Town or Location

Abington

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

2857 Old Philadelphia Rd.

10f. Zip Code

21009

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

U.S. Government Courier

16b. Kind of Business/Industry

Aberdeen Proving Ground

17. Father's Name (First, Middle, Last)

Henry H. Turner

18. Mother's Name (First, Middle, Maiden Surname)

Clara Broadway Turner

19a. Informant's Name/Relationship (Type, Print)

Denise Harris (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

174 Topview Drive Edgewood, Maryland 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

John Wesley Church Cem.

Date

7/26/00

20c. Location - City or Town, State

Abington, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Ave. Balto., Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Renal Failure

Due to (or as a consequence of):

b.

Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

c.

Aneurysm

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

Inpatient ☒ ER/Outpatient ☐ DOA ☐

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

Drobbel

29d. Date signed (Month, Day, Year)

7/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. T. Lee M.D. 665 Revolution St. Havre de Grace MD 21028

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerPhysician  
/Medical  
Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23238

## Certificate of Death

Reg. No.

|                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             |                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><i>Thomas Robert Thornton</i>                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 2. Date of Death<br>Month <i>July</i> Day <i>21</i> Year <i>2000</i>                                                                                                                                                                                                             |                                                             | 3. Time of Death<br><i>2:00AM</i>                                                                                                                                                                |
|                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><i>University of Maryland Medical System</i>                                                                                                                                                                                                                                                                                                               |                                                                            | 4b. City, Town, or Location of Death<br><i>Baltimore</i>                                                                                                                                                                                                                         |                                                             | 4c. County of Death<br><i>N/A</i>                                                                                                                                                                |
| Funeral<br>Director                                                                                                                                 | 5. Social Security Number<br><i>216-14-4878</i>                                                                                                                                                                                                                                                                                                                                                                              | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>79</i> Yrs.                                                                                                                                                                                                                                 | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   |
|                                                                                                                                                     | 8. Date of Birth (Month, Day, Year)<br><i>May 1, 1921</i>                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>                                                                                                                                                                                                                      |                                                             |                                                                                                                                                                                                  |
| To Be Completed by Funeral Director                                                                                                                 | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | 10a. State<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                | 10b. County<br><i>Harford</i>                                              | 10c. City, Town or Location<br><i>Bel Air</i>                                                                                                                                                                                                                                    |                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |
|                                                                                                                                                     | 10e. Street and Number<br><i>217 Princeton Lane</i>                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 10f. Zip Code<br><i>21014</i>                                                                                                                                                                                                                                                    |                                                             | 10g. Citizen of What Country?<br><i>United States</i>                                                                                                                                            |
|                                                                                                                                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>WWII</i>                                                                                                                    |                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|                                                                                                                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>white</i>                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> <i>4</i>                                                                                          |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>sales representative</i>                                                                                                                                                                                                                                                                                     |                                                                            | 16b. Kind of Business/Industry<br><i>marine stores</i>                                                                                                                                                                                                                           |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | 17. Father's Name (First, Middle, Last)<br><i>George Joseph Thornton</i>                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Storck</i>                                                                                                                                                                                                          |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | 19a. Informant's Name/Relationship (Type, Print)<br><i>Lucille Thornton/wife</i>                                                                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>217 Princeton Lane Bel Air, MD 21014</i>                                                                                                                                     |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Greenmount Crematory</i>                                                                                                                                                                            |                                                             | 20c. Location - City or Town, State<br><i>7/24/00 Baltimore, Maryland</i>                                                                                                                        |
|                                                                                                                                                     | 21. Signature of Funeral Service Licensee<br><i>John D. Mitchell</i>                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 22. Name and Address of Facility<br><i>Mitchell-Wiedefeld Funeral Home, Inc.<br/>6500 York Rd.<br/>Baltimore, MD 21212</i>                                                                                                                                                       |                                                             |                                                                                                                                                                                                  |
| Physician<br>/Medical<br>Examiner                                                                                                                   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>Intra-aortic hemorrhage</i>                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             | Approximate Interval Between Onset and Death                                                                                                                                                     |
|                                                                                                                                                     | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Acute myocardial infarction</i>                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                                                                                                                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
|                                                                                                                                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                           | 28b. Time of Injury<br><i>M</i>                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |
|                                                                                                                                                     | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                     |                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                     | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                              | 29c. License number<br><i>A2446</i>                                        |                                                                                                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br><i>July 21, 2000</i> |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>T. Mitchell MD 22 South Grove St Baltimore, MD 21201</i> |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                  |                                                             |                                                                                                                                                                                                  |
| State<br>Registrar                                                                                                                                  | 31. Date filed (Month, Day, Year)<br><i>JUL 24 2000</i>                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                  |                                                             |                                                                                                                                                                                                  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23239

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

GAYLORD ALVIN TARR

2. Date of Death

Month Day Year  
JULY 18, 2000 10:10 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-22-7981

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 18, 1928

9. Birthplace (State or Foreign Country)

Washington, PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4339 Chapel Road

10f. Zip Code

21128

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (14 or 5+)

4 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Carpentry teaching

16b. Kind of Business/Industry

Teaching Industry

17. Father's Name (First, Middle, Last)

Stewart Alvin Tarr

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Gertrude Beecham

19a. Informant's Name/Relationship (Type, Print)

Mrs. Avis Tarr (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4339 Chapel Road Perry Hall, MD 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gardens Of Faith

Date

7/22/2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E.F. Lassahn Funeral Home

11750 Belair Rd. Kingsville, MD 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

RESPIRATORY ARREST

a. Due to (or as a consequence of):

CONGESTIVE HEART FAILURE

b. Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

c. Due to (or as a consequence of):

CARDIOMYOPATHY - HYPERTENSIVE ARTERIO-

SCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Armando A. Real

29c. License number

D 24710

29d. Date signed (Month, Day, Year)

7-19-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARMANDO A. REAL, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Benita Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23240

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                                                                                                            |                                 |                                                                                                                                                                                |                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Mollie C. Trivett</b>                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 17, 2000</b> |                                                                                                                                                                                                                                                                            |                                 |                                                                                                                                                                                | 3. Time of Death<br><b>03:50 PM</b>           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Towson</b>      |                                                                                                                                                                                                                                                                            |                                 |                                                                                                                                                                                | 4c. County of Death<br><b>Baltimore</b>       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>215-34-7518</b>                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.           |                                                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days  |                                                                                                                                                                                | If Under 24 Hrs.<br>Hours Min.                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 17, 1908</b>                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 9. Birthplace (State or Foreign Country)<br><b>Fairchance, PA</b>          |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                    |                                                                                                                                                                                                                                                                            | 10b. County<br><b>Baltimore</b> |                                                                                                                                                                                | 10c. City, Town or Location<br><b>Baldwin</b> |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                      | 10e. Street and Number<br><b>13606 Manor Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 10f. Zip Code<br><b>21013</b>                                                                                                                                                                                                                                                               |                                                            | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                |                                 | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                               |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                            |                                                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                     |                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+) <b>N/A</b>                                                                                                                           |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cafeteria Manager</b>                                          |                                               |  |
| 16b. Kind of Business/Industry<br><b>Balto. County Board of Ed.</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      | 17. Father's Name (First, Middle, Last)<br><b>William Elihu Carlton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Naomi Vivian Houck</b>                                                                                                                                                                                                              |                                                            | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeanette Baker (daughter)</b>                                                                                                                                                                                       |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9023 Old Harford Rd Balto. MD 21234</b>                                    |                                               |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | Date<br><b>7/21/00</b>                                                                                                                                                                                                                                                                      |                                                            | 20c. Location - City or Town, State<br><b>Timonium, MD</b>                                                                                                                                                                                                                 |                                 | 21. Signature of Funeral Service Licensee<br>                                                                                                                                  |                                               |  |
| 22. Name and Address of Facility<br><b>E.F. Lassahn Funeral Home</b><br><b>11750 Belair Rd. Kingsville, MD 21087</b>                                                                                                                                                                                                                                                                                                         |                                                                                                      | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>CONGESTIVE HEART FAILURE</b><br>a. Due to (or as a consequence of):<br><br><b>RENAL FAILURE</b><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                            | Approximate Interval Between Onset and Death<br><b>11 DAYS</b>                                                                                                                                                                                                                              |                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                           |                                 | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                          |                                               |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                           |                                                                                                      | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                 | 28a. Date of Injury (Month, Day Year)<br><b>7/20/00</b>                                                                                                                        |                                               |  |
| 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                     |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |                                               |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                      | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 29c. License number<br><b>D 29306</b>                                                                                                                                                                                                                                                       |                                                            | 29d. Date signed (Month, Day, Year)<br><b>7/20/00</b>                                                                                                                                                                                                                      |                                 | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ALFONSO P. ZALDUONDO, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204</b>             |                                               |  |
| 31. Data filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 33. Date of Death<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                     |                                                            | 34. Time of Death<br><b>03:50 PM</b>                                                                                                                                                                                                                                       |                                 | 35. Place of Death<br><b>Towson, MD</b>                                                                                                                                        |                                               |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23241

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                 |  |                          |                                                                                                                                                                                                                                                                                                                                                                           |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>Nicholas Weil</b>                                                |  |                          |                                                                                                                                                                                                                                                                                                                                                                           | 2. Date of Death<br>Month <b>July</b> Day <b>23</b> Year <b>2000</b> |  |                                                             |                                                                                                                                               | 3. Time of Death<br><b>12:40 pm</b>                   |  |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4e. Facility Name (If not institution, give street and number)<br><b>Future Care Canton Harbor Nursing Home</b> |  |                          |                                                                                                                                                                                                                                                                                                                                                                           | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>        |  |                                                             |                                                                                                                                               | 4c. County of Death<br><b>N/A</b>                     |  |                                                      |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>212-09-2443</b>                                                                 |  | 6. Sex<br><b>XXM 2□F</b> |                                                                                                                                                                                                                                                                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 17, 1911</b> |                                                                                                                                               | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                                     |  |                          |                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>MD</b>                                              |  |                                                             |                                                                                                                                               | 10b. County<br><b>N/A</b>                             |  | 10c. City, Town or Location<br><b>Baltimore City</b> |
| 10e. Street and Number<br><b>202 East Randall Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                 |  |                          | 10f. Zip Code<br><b>21230</b>                                                                                                                                                                                                                                                                                                                                             |                                                                      |  |                                                             | 10g. Citizen of What Country?<br><b>United States</b>                                                                                         |                                                       |  |                                                      |
| 11. Marital Status<br><b>XX Widowed 4□ Divorced</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 |  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1XX Yes 2□ No Army WWII</b>                                                                                                                                                                                                                                                                                             |                                                                      |  |                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1□ Yes 2XX No Specify:</b> |                                                       |  |                                                      |
| 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 |  |                          | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0</b>                                                                                                                                                                                                                                             |                                                                      |  |                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Store Keeper</b>              |                                                       |  |                                                      |
| 16b. Kind of Business/Industry<br><b>Sales</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                 |  |                          | 17. Father's Name (First, Middle, Last)<br><b>Frank Weil</b>                                                                                                                                                                                                                                                                                                              |                                                                      |  |                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa Seriatz</b>                                                                   |                                                       |  |                                                      |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Theresa Weil / Niece</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                 |  |                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1444 Towson Street, Baltimore Maryland 21230</b>                                                                                                                                                                                                                      |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
| 20a. Method of Disposition<br><b>XX Burial 2□ Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                 |  |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cem. July 25, 2000</b>                                                                                                                                                                                                                                                            |                                                                      |  |                                                             | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b>                                                                              |                                                       |  |                                                      |
| 21. Signature of Funeral Service Licensee<br><b>Victor P. Doda, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 |  |                          | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230</b>                                                                                                                                                                                                                                          |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Acute Coronary Artery Occlusion</b><br>Due to (or as a consequence of):<br>c. <b>Coronary Arteriosclerosis</b><br>Due to (or as a consequence of):<br>d. |                                                                                                                 |  |                          | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                                                                                              |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b><br><b>Osteoporesis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 |  |                          | 23b. Did tobacco use contribute to the cause of death?<br><b>1□ Yes 2□ No 3□ Probably 4XX Unknown</b>                                                                                                                                                                                                                                                                     |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
| 24a. Was an autopsy performed?<br><b>1□ Yes 2XX No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                 |  |                          | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1□ Yes 2XX No</b>                                                                                                                                                                                                                                                                       |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
| 25. Was case referred to medical examiner?<br><b>1□ Yes 2XX No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                 |  |                          | 26. Place of Death (Check only one)<br>Hospital: <b>1□ Inpatient 2□ ER/Outpatient 3□ DOA</b> Other: <b>4XX Nursing Home 5□ Residence 6□ Other (Specify)</b>                                                                                                                                                                                                               |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
| 27. Manner of Death<br><b>XX Natural 5□ Pending investigation 2□ Accident 6□ Could not be determined 3□ Suicide 4□ Homicide</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                 |  |                          | 28a. Date of Injury (Month, Day Year)<br><b>M</b>                                                                                                                                                                                                                                                                                                                         |                                                                      |  |                                                             | 28b. Time of Injury<br><b>1□ Yes 2□ No</b>                                                                                                    |                                                       |  |                                                      |
| 28c. Injury at Work?<br><b>1□ Yes 2□ No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 |  |                          | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                         |                                                                      |  |                                                             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                        |                                                       |  |                                                      |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                 |  |                          | 29a. Certifier (Check only one)<br><b>XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
| 29b. Signature and title of certifier<br><b>Joseph D. Notarangelo M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                 |  |                          | 29c. License number<br><b>D07316</b>                                                                                                                                                                                                                                                                                                                                      |                                                                      |  |                                                             | 29d. Date signed (Month, Day, Year)<br><b>July 24, 2000</b>                                                                                   |                                                       |  |                                                      |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Joseph D. Notarangelo, M.D. 301 St. Paul Place, PO Box 701, Baltimore MD 21202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 |  |                          | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                   |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |
| 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                 |  |                          |                                                                                                                                                                                                                                                                                                                                                                           |                                                                      |  |                                                             |                                                                                                                                               |                                                       |  |                                                      |





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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br><b>Catherine White</b>                               |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>2000</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>1300</b>                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b> |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |                                                                                                                                                                                                  | 4c. County of Death<br><b>NA</b>                                                                                 |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br><b>134-32-3552</b>                                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth (Month, Day, Year)<br><b>06-01-34</b>                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>VA</b>                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                                      |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  | 10b. County<br><b>NA</b>                                                                                                                                                                                                                                                                    |                                                  | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                              |                                                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                                                                                                  |
| 10e. Street and Number<br><b>1750 Montpelier Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                |                                                                      | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                          |                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b><br>College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>                                                                 |                                                                      | 16b. Kind of Business/Industry<br><b>in home</b>                                                                                                                                                 |                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter Washington</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie Rush</b>                                                                                                                      |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Georgia Washington</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>321 East 21 1/2 Street Baltimore, MD. 21218</b>                                          |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Voshell Mem. Gardens</b>                                                                                                                                                                                       |                                                  | 20c. Date<br><b>07-25-2000</b>                                                                                                                                                               |                                                                      | 20d. Location - City or Town, State<br><b>Dundalk, MD</b>                                                                                                                                        |                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202<br/>WM.C.March FH 1101 E. North Avenue</b>                                                                                  |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Multiple System Organ Failure</b><br>Due to (or as a consequence of):<br>b. <b>Septic Shock</b><br>Due to (or as a consequence of):<br>c. <b>Acute Renal Failure</b><br>Due to (or as a consequence of):<br>d. <b>Ischemic Bowel</b> |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br><b>4 days</b><br><b>5 days</b><br><b>4 days</b><br><b>4 days</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |                                                                                                                  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                       |                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                         |                                                                                                  | 29b. Signature and title of certifier<br><b>Vicki Hubbard, MD</b>                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  | 29c. License number<br><b>AT2438946</b>                                                                                                                                                                                                                                                     |                                                  | 29d. Date signed (Month, Day, Year)<br><b>July 19, 2000</b>                                                                                                                                  |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vicki Hubbard</b><br><b>201 E. University Pkwy, Baltimore, MD 21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                                  |



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State of Maryland / Department of Health and Mental Hygiene 00 23243

## Certificate of Death

Reg. No.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Rosa Sacks Wall</b>                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. Date of Death<br>Month <b>July</b> Day <b>18</b> Year <b>2000</b> |                                                                                                                                                                                                                                                                         | 3. Time of Death<br><b>6:00A.</b>                           |                                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Bedford Court Nursing Home</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>         |                                                                                                                                                                                                                                                                         | 4c. County of Death<br><b>Montgomery</b>                    |                                                                                                                                                                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>578-28-7906</b>                                                     |                                                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.                     |                                                                                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 21, 1910</b> |                                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                         |                                                                                                                                                   | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10b. County<br><b>Montgomery</b>                                     |                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br><b>Rockville</b>             |                                                                                                                                                                             |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                     | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                    |                                                                            | 10e. Street and Number<br><b>14808 Marlin Terrace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                      | 10f. Zip Code<br><b>20853</b>                                                                                                                                                                                                                                           |                                                             | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                       |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                  |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                 |                                                             |                                                                                                                                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                  |                                                                                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Legal Secretary</b>               |                                                                            | 16b. Kind of Business/Industry<br><b>Law Firm</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                      | 17. Father's Name (First, Middle, Last)<br><b>Louis Sacks</b>                                                                                                                                                                                                           |                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Caplin</b>                                                                                                    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ada W. Sheinbaun (daughter)</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b>                               |                                                                            | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                          |                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Lebanon Cemetery</b>                                                                                                                                                                   |                                                             | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>                                                                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                     | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>             |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Alzheimer's Disease</b><br>Due to (or as a consequence of):<br><b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertension</b> |                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                        |                                                             | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                       |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                           |                                                                                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                    |                                                                      | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                             | 28a. Date of Injury (Month, Day, Year)<br><b>July 18, 2000</b>                                                                                                              |  |
| 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                       |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                  |                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                     | 29b. Signature and title of certifier<br>                                                                                                         |                                                                            | 29c. License number<br><b>208381</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>July 18, 2000</b>                                                                                                                                                                                                             |                                                             | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Benjamin Avrunin, M.D. 18111 Prince Philip Drive, #209 Olney, Maryland 20832</b> |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                     | 32. Registrar's Signature<br>                                                                                                                     |                                                                            | 33. Registrar's Name<br><b>APR 1 2004</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                      | 34. Registrar's Title<br><b>ORIGINAL</b>                                                                                                                                                                                                                                |                                                             |                                                                                                                                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2028.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #17 PER F.H. G785 7-24-00 WR. 00 23244

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE WAXTER

2. Date of Death

Month JULY Day 20 Year 2000

3. Time of Death

9:20 AM

4a. Facility Name (If not institution, give street and number)

oakcrest care center

4b. City, Town, or Location of Death

Baltimore County

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-20-9799

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month OCT Day 23 Year 1907

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaking-Own Home

17. Father's Name (First, Middle, Last)

~~Charles Waxter~~

CHARLES LOEFFLER

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Dauman

19a. Informant's Name/Relationship (Type, Print)

George Waxter, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7916 River Run Ct. Frederick, Md. 21701

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodlawn Cemetery

Date

7-25-00

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

*Richard L. Hess*

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Md. 21236

23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. *End Stage Dementia*

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

*years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Cerebral Vascular Disease, Stroke,*

*Osteoarthritis.*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident  
3 ☐ Suicide 6 ☐ Could not be  
determined  
4 ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Susan G. Weiner MD*

29c. License number

*D34941*

29d. Date signed (Month, Day, Year)

*July 20, 2000*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Susan G. Weiner MD, 8800 Walther Blvd. Parkville, Md 21234.*

31. Date filed (Month, Day, Year)

*JUL 24 2000*

32. Registrar's Signature

*Bonnie B. Sparks*

State  
Registrar

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, 5  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

WAXTER





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23245

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>ANNIE MAE WILLIAMS</b>                       |                                                                                                                                                                                        | 2. Date of Death<br>Month Day Year<br><b>JULY 14, 2000</b> |                                                                                                                                                       | 3. Time of Death<br><b>20:34</b>  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not Institution, give street and number)<br><b>ST. AGNES HOSPITAL</b> |                                                                                                                                                                                        | 4b. City, Town, or Location of Death<br><b>BALTO.</b>      |                                                                                                                                                       | 4c. County of Death<br><b>N/A</b> |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>218-14-5566</b>                                             | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                         | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.           | If Under 1 Year<br>Months Days                                                                                                                        | If Under 24 Hrs.<br>Hours Min.    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>6-19-1924</b>                                     |                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><b>MD</b>      |                                                                                                                                                       |                                   |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             | 10b. County<br><b>BALTIMORE</b>                                                                                                                                                        |                                                            | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                       |                                   |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                             | 10e. Street and Number<br><b>1520 W. NORTH AVE. APT. 610</b>                                                                                                                           |                                                            | 10f. Zip Code<br><b>21216</b>                                                                                                                         |                                   |
| 10g. Citizen of What Country?<br><b>U.S.A</b>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                |                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                          |                                   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RETIRED</b>                                                                                                                                                                                                                                                                                                   |                                                                                             | 16b. Kind of Business/Industry<br><b>JENKINS MEMORIAL NURSING HOME</b>                                                                                                                 |                                                            | 17. Father's Name (First, Middle, Last)<br><b>DAVID PHILLIPS</b>                                                                                      |                                   |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EVA GREEN</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                             | 19a. Informant's Name/Relationship (Type, Print)<br><b>GRAND-SHA MAI WILDER ( DAUGHTER)</b>                                                                                            |                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>748 CHARINGCROSS ROAD BALTO. MD 21229</b>         |                                   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEM PARK</b>                                                                                      |                                                            | 20c. Location - City or Town, State<br><b>7-20-2000 ARBUTUS MD</b>                                                                                    |                                   |
| 21. Signature of Funeral Service Licensee<br><i>Eugene Walker</i>                                                                                                                                                                                                                                                                                                                                                             |                                                                                             | 22. Name and Address of Facility<br><b>ESTEP BROS. FUNERAL SERV. 1300 EUTAW PLACE BALTO. MD 21217</b>                                                                                  |                                                            |                                                                                                                                                       |                                   |
| 23a. Part I. Enter the disease or communication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.                                                                                                                                                                                                                      |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| a. <u>myocardial infarction</u><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                           |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| b. <u>Hypertension</u><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| c.<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| d.<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                    |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Gastric cancer.</u>                                                                                                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                      |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                          |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                             | 28a. Date of Injury (Month, Day Year)                                                                                                                                                  |                                                            | 28b. Time of Injury<br>M                                                                                                                              |                                   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |                                                                                             | 28d. Describe how injury occurred                                                                                                                                                      |                                                            | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                          |                                   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 29b. Signature and title of certifier<br><i>DR. J. S. MD</i>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             | 29c. License number<br><b>BG5848995</b>                                                                                                                                                |                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 14, 2000</b>                                                                                           |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert Greenwald M.D. 900 Carter Avenue St Agnes Hospital 21229</b>                                                                                                                                                                                                                                                                |                                                                                             |                                                                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                        |                                                            |                                                                                                                                                       |                                   |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23246

## Certificate of Death

Reg. No.

|                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                                                              |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><i>MARY WILLIAMS</i>                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 2. Date of Death<br>Month <i>July</i> Day <i>19</i> Year <i>2000</i>                                                                                                                                                                                                       |                                                                                             | 3. Time of Death<br><i>20:15</i>                                                                                                                                                             |
|                                                         | 4a. Facility Name (If not institution, give street and number)<br><i>JOHNS HOPKINS BAYVIEW Medical Center</i>                                                                                                                                                                                                                                                                                                             |                                                                            | 4b. City, Town, or Location of Death<br><i>BALTIMORE</i>                                                                                                                                                                                                                   |                                                                                             | 4c. County of Death<br><i>NA</i>                                                                                                                                                             |
| Funeral<br>Director                                     | 5. Social Security Number<br><i>244-44-6045</i>                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>76</i> Yrs.                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><i>November 9, 1923</i>                              | 9. Birthplace (State or Foreign Country)<br><i>SC</i>                                                                                                                                        |
|                                                         | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                                                              |
| To Be Completed by Funeral Director                     | 10a. State<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><i>NA</i>                                                   | 10c. City, Town or Location<br><i>BALTIMORE</i>                                                                                                                                                                                                                            |                                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               |
|                                                         | 10e. Street and Number<br><i>122 S. Mount Street</i>                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 10f. Zip Code<br><i>21223</i>                                                                                                                                                                                                                                              |                                                                                             | 10g. Citizen of What Country?<br><i>USA</i>                                                                                                                                                  |
|                                                         | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                 |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                          |                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>African American</i>                                                                                                                                                                                                                                                                                                                                        |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>5th</i> College (1-4 or 5+) <i>0</i>                                                                                                                                     |                                                                                             |                                                                                                                                                                                              |
| To Be Completed by Physician/Medical Examiner           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Laborer</i>                                                                                                                                                                                                                                                                                               |                                                                            | 16b. Kind of Business/Industry<br><i>Laundry</i>                                                                                                                                                                                                                           |                                                                                             |                                                                                                                                                                                              |
|                                                         | 17. Father's Name (First, Middle, Last) <i>unk</i>                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Annie Rebecca Wilder</i>                                                                                                                                                                                           |                                                                                             |                                                                                                                                                                                              |
|                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><i>Thelma Williams daughter</i>                                                                                                                                                                                                                                                                                                                                       |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>122 S. Mount St. Baltimore MD 21223</i>                                                                                                                                |                                                                                             |                                                                                                                                                                                              |
|                                                         | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Arbutus Memorial</i>                                                                                                                                                                          |                                                                                             | 20c. Location - City or Town, State<br><i>Baltimore, MD</i>                                                                                                                                  |
| Physician<br>/Medical<br>Examiner                       | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 22. Name and Address of Facility<br><i>Wynne Funeral Home Inc<br/>638 N. Eulmor St. Balt. MD 21217</i>                                                                                                                                                                     |                                                                                             |                                                                                                                                                                                              |
|                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Interstitial Pulmonary Fibrosis</i><br>Due to (or as a consequence of):                                                             |                                                                            |                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                                                              |
|                                                         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                                                              |
|                                                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                                                              |
| To Be Completed by Physician/Medical Examiner           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                      |                                                                                             |                                                                                                                                                                                              |
|                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                            | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                          |                                                                                             |                                                                                                                                                                                              |
|                                                         | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |                                                                                             |                                                                                                                                                                                              |
|                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                              |
| State<br>Registrar                                      | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                               |                                                                                             |                                                                                                                                                                                              |
|                                                         | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                                                              |
|                                                         | 29b. Signature and title of certifier<br><i>W. J. [Signature]</i>                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 29c. License number<br><i>21007</i>                                                                                                                                                                                                                                        |                                                                                             | 29d. Date signed (Month, Day, Year)<br><i>July 19, 2000</i>                                                                                                                                  |
|                                                         | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>William Hung MD 4940 Eastern Avenue Baltimore, Maryland 21224</i>                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                                                              |
| 31. Date filed (Month, Day, Year)<br><i>JUL 24 2000</i> |                                                                                                                                                                                                                                                                                                                                                                                                                           | 32. Registrar's Signature<br><i>[Signature]</i>                            |                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                                                              |



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State of Maryland / Department of Health and Mental Hygiene

00 23247

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            |  |                                                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT C. WILES</b>                                         |  |                                                                                                                                                               |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>July 12, 2000</b>                                                                                                                                   |                                                                                        | 3. Time of Death<br><b>1020</b>                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b> |  |                                                                                                                                                               |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>                                                                                                                                     |                                                                                        | 4c. County of Death<br><b>WICOMICO</b>                                                         |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br><b>214-30-8110</b>                                                            |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                    |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.                                                                                                                                             |                                                                                        | 8. Date of Birth (Month, Day, Year)<br><b>Aug 24, 1909</b>                                     |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10a. State<br><b>MD</b>                                                                                    |  | 10b. County<br><b>Somerset</b>                                                                                                                                |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Princess Anne</b>                                                                                                                                          |                                                                                        | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                            |  |                                                                                                                                                               | 10e. Street and Number<br><b>13988 Allen Road</b>                                                                                                                                                                                                                                           |                                                                                                                                                                                              | 10f. Zip Code<br><b>21853</b>                                                          |                                                                                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                        |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                            |  |                                                                                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>photographer</b>                                                                                                                                                            |                                                                                                                                                                                              |                                                                                        | 16b. Kind of Business/Industry<br><b>self employed</b>                                         |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert S. Wiles</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                            |  |                                                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie E. Wiles</b>                                                                                                                                                                                                                 |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeanne Wiles/daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                            |  |                                                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13988 Allen Rd Princess Anne, MD 21853</b>                                                                                                                                              |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                            |  |                                                                                                                                                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                      |                                                                                                                                                                                              | Date                                                                                   |                                                                                                | 20c. Location - City or Town, State                                                                                                                                                              |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph B. Van Sant</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                            |  |                                                                                                                                                               | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                                                                                                                                                                                  |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute Renal failure</b><br>Due to (or as a consequence of):<br>b. <b>Respiratory insufficiency</b><br>Due to (or as a consequence of):<br>c. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                            |  |                                                                                                                                                               | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                            |  |                                                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                        |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            |  |                                                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                        |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            |  |                                                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                        |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                            |  |                                                                                                                                                               | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                            |  |                                                                                                                                                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                                                              | 28b. Time of Injury<br>M                                                               |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            |  |                                                                                                                                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                                                              | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            |  |                                                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                      |                                                                                                            |  |                                                                                                                                                               | 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                 |                                                                                                                                                                                              | 29c. License number<br><b>D29105</b>                                                   |                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>7/13/00</b>                                                                                                                                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHRISTOPHER HUGHES, M.D. 104 MILVOD ST. SALISBURY, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                            |  |                                                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                            |  |                                                                                                                                                               | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                        |                                                                                                |                                                                                                                                                                                                  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23248

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NORMAN W. WOOD

2. Date of Death

JULY 18, 2000

3. Time of Death

1:05 PM

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-05-2697

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 4, 1908

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

115 Linden Terrace

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: unk13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CPA

16b. Kind of Business/Industry

accounting

17. Father's Name (First, Middle, Last)

Robert B. Wood

18. Mother's Name (First, Middle, Maiden Surname)

Mary V. Pierce

19a. Informant's Name/Relationship (Type, Print)

Jean Wood/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

115 Linden Terrace Towson, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Liver cancer  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley BMC 16701 N. Charles St. Balt. MD 21207

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23249

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Carr Wickert

2. Date of Death

Month Day Year  
July 20, 2000

3. Time of Death

11:30 p.m.

4a. Facility Name (If not institution, give street and number)

Harford Gardens Nursing Home

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-14-0202

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 23, 1921

9. Birthplace (State or Foreign Country)

Hanover, PA

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2622 Burrigle Road

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Steel Production

17. Father's Name (First, Middle, Last)

Walter C. Wickert

18. Mother's Name (First, Middle, Maiden Surname)

Sarah (Not Known)

19a. Informant's Name/Relationship (Type, Print)

Marie R. Wickert (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2622 Burrigle Road Baltimore, Maryland 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp. 7/22/00

Date

20c. Location - City or Town, State

Towson Maryland

21. Signature of Funeral Service Licensee

Milton J. Knight Jr.  
Milton J. Knight Jr.

22. Name and Address of Facility

Leonard J. Ruck, Inc.  
5305 Harford Road Baltimore, Maryland 2121423a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause in each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Dehydration

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

&gt; 1 wk

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Dementia

Due to (or as a consequence of):

&gt; 1 yrs.

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Khan MD

29c. License number

D25391

29d. Date signed (Month, Day, Year)

7-21-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. KHAN, 5601- Loch Raven Blvd, Baltimore MD 21239

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23250

Amended item 31 per dvr g785 7-24-00 wj

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paula

Walter

2. Date of Death

Month  
JulyDay  
16,Year  
2000

3. Time of Death

3:30pm

4a. Facility Name (If not Institution, give street and number)

1924 Robinwood Rd.

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-64-8774

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 20, 1906

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1924 Robinwood Rd

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7 yrs

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

House wife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Peter Naumann

18. Mother's Name (First, Middle, Maiden Surname)

Maria Schmidt

19a. Informant's Name/Relationship (Type, Print)

Ernest Walter

son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1924 Robinwood Rd. Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith Cem

Data

July 22

20c. Location - City or Town, State

Rosedale, Md.

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A.

7110 Sollers Point Rd. Dundalk, Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Atrial Fibrillation

8 yrs.

Due to (or as a consequence of):

b. Dementia of Alzheimer

3 yrs.

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44793

29d. Date signed (Month, Day, Year)

7/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SARAH

6730

HOLABIRD AVE.

DUNDALK MD

21222

31. Date filed (Month, Day, Year)

07-19-00 JUL 24 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23251

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HYUN SOOK Yim

2. Date of Death

Month Day Year

July 32 2000

3. Time of Death

0542

4a. Facility Name (If not institution, give street and number)

7853 AMERICANA Circle #202

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

AA

Funeral  
Director

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 12, 1908

9. Birthplace (State or Foreign)

Korea

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7853 Americana Circle Apt. 202

10f. Zip Code

21061

10g. Citizen of What Country?

Korea

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown Yim

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Kwan Kim/Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2959 Pebble Beach Drive Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Mem. Gardens

Date

July 24,

20c. Location - City or Town, State

2000 Davidsonville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home P.A.

421 Crain Hwy. S.E. Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Deputy

29c. License number

D06054

29d. Date signed (Month, Day, Year)

7/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23252

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)  
Baby Boy Zuzolo

2. Date of Death  
Month Day Year  
June 9, 2000

3. Time of Death  
12:05 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number  
none

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
June 9, 2000

9. Birthplace (State or Foreign  
Country)  
MD

Usual Residence of Decedent

10a. State  
MD

10b. County  
Harford

10c. City, Town or Location  
Belair

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

659 Red Oak Drive

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.  
Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
0

College (14 or 5+)  
0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
none

16b. Kind of Business/Industry  
none

17. Father's Name (First, Middle, Last)

Phillip Zuzolo

18. Mother's Name (First, Middle, Maiden Surname)

Martes Bereber

19a. Informant's Name/Relationship (Type, Print)

Franklin Square Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9000 Franklin Square Drive Baltimore, MD 21237

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St.  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Anencephaly

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident  
3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Dwyer MD

29c. License number

RD 199026

29d. Date signed (Month, Day, Year)

July 12, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Michael Dwyer 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Bernice B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23253

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John L. Zimmerer

2. Date of Death

Month Day Year  
July 19, 2000

3. Time of Death

12:40AM

4a. Facility Name (If not institution, give street and number)

Gilcrest Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Balto.

Funeral  
Director

5. Social Security Number

219-14-2214

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 18, 1924

9. Birthplace (State or Foreign Country)

Balto. Md

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1403 Terry Way

10f. Zip Code

21047

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 yearsCollege (14 or 5+)  
4 years16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Agent

16b. Kind of Business/Industry

Internal Revenue Service

17. Father's Name (First, Middle, Last)

George Zimmerer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Tremper

19a. Informant's Name/Relationship (Type, Print)

Regina Zimmerer (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1403 Terry Way Fallston, MD 21047

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☒ Other (Specify) Intombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BelAir Memorial Gardens-Mausoleum

Date

7/21/00

20c. Location - City or Town, State

BelAir, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

E.F. Lassahn Funeral  
11750 Belair Rd. Kingsville, MD 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)a. pancreatic Cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death1 yearSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D25205

29d. Date signed (Month, Day, Year)

July 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley 6601 N. Charles St. Balto. Md

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

2120x

ZIMMERER, JOHN JULY 19, 2000 @ 12:40 AM

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Amended # 16A mlu  
Allegany Co 7/11/00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23254

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>ROBERT EARL ADAMS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                               |  | 2. Date of Death<br>Month Day Year<br>JULY 9 2000                                                                                                                                                                                                                                                       |  |                                                                                      |                                                                  | 3. Time of Death<br>2:07PM                                                                     |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>10103 HILLCREST DRIVE N.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                               |  | 4b. City, Town, or Location of Death<br>CUMBERLAND                                                                                                                                                                                                                                                      |  |                                                                                      |                                                                  | 4c. County of Death<br>ALLEGANY                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-34-4366                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                    |  | 7. Age (In yrs. last birthday)<br>62 Yrs.                                                                                                                                                                                                                                                               |  | 8. Date of Birth (Month, Day, Year)<br>AUGUST 23 1937                                |                                                                  | 9. Birthplace (State or Foreign Country)<br>MARYLAND                                           |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
| To Be Completed by Funeral Director           | 10a. State<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. County<br>ALLEGANY                                                                                                                                       |  | 10c. City, Town or Location<br>CUMBERLAND                                                                                                                                                                                                                                                               |  |                                                                                      |                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 10e. Street and Number<br>10103 HILLCREST DRIVE N.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                               |  | 10f. Zip Code<br>21502                                                                                                                                                                                                                                                                                  |  | 10g. Citizen of What Country?<br>U.S.A.                                              |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates 960-1960 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                       |  |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                               |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Supervisor Graining Dept.<br>CELANESE CORP OF AMERICA                                                                                                                                      |  |                                                                                      |                                                                  | 16b. Kind of Business/Industry<br>SILK MANUF.                                                  |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 17. Father's Name (First, Middle, Last)<br>PALMER E. ADAMS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                               |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY ANNA TAYLOR                                                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>SANDRA J. ADAMS WIFE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                               |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10103 HILLCREST DRIVE CUMBERLAND MARYLAND 21502                                                                                                                                                        |  |                                                                                      |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                 |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SUNSET CEMETERY JULY 12 2000                                                        |  | Data<br>CUMBERLAND MARYLAND                                                                                                                                                                                                                                                                             |  | 20c. Location - City or Town, State                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 21. Signature of Funeral Service Licensee<br>Dale L. Merritt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                               |  | 22. Name and Address of Facility<br>MERRITT-ADAMS FUNERAL HOME P.A.<br>404 DECATUR STREET CUMBERLAND MARYLAND                                                                                                                                                                                           |  |                                                                                      |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Esophageal Adenocarcinoma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                  |                                                                                                |  | Approximate Interval Between Onset and Death<br>UNKNOWN                                                                                                                                                  |  |                                        |  |                                                      |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                  |                                                                                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |                                        |  |                                                      |  |
| State<br>Registrar                            | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                               |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                      |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                       |  | 28a. Date of Injury (Month, Day Year)                                                                                                                         |  | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                              |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                      |                                                                  |                                                                                                |  |                                                                                                                                                                                                          |  |                                        |  |                                                      |  |
|                                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                   |  |                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                  |                                                                                                |  | 29b. Signature and title of certifier<br>R. E. Rapp MD                                                                                                                                                   |  | 29c. License number<br>D54756          |  | 29d. Date signed (Month, Day, Year)<br>JULY 10, 2000 |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. ROBERT E. RAPP 912 SETON DRIVE CUMBERLAND MARYLAND 21502                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                  |                                                                                                |  | 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                         |  | 32. Registrar's Signature<br>B. Sparks |  |                                                      |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or date, appearing as "1900" or similar.

1900



Amended #s 9, 12,  
23a(a), NLS, Allegany Co.

Amended # 5 mlv  
Allegany Co 7/11/00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23255

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN LELAND BOOTH

2. Date of Death

Month Day Year  
July 02, 2000

3. Time of Death

23:40 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

271-14-2990

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APR 17, 1916

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

LAVALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

104 MUSTOPHAL DRIVE

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTING OFFICE

16b. Kind of Business/Industry

RAILROAD

17. Father's Name (First, Middle, Last)

JOSEPH SIMPSON BOOTH

18. Mother's Name (First, Middle, Maiden Surname)

ANNA KINGSTON

19a. Informant's Name/Relationship (Type, Print)

MATILDA JANE BOOTH/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 MUSTOPHAL DR., LAVALE, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ROCKY GAP

VETERANS CEMETERY

Date

JULY

6, 2000

20c. Location - City or Town, State

FLINTSTONE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HAFFER CHAPEL OF THE HILLS MORTUARY

1302 NATIONAL HWY., LAVALE, MD 21502

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Arteriosclerotic cardiovascular disease

Immediate Cause (Final disease or condition resulting in death)

RENAL FAILURE

Approximate Interval Between Onset and Death

THREE WEEKS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

SEPSIS SYNDROME

RESPIRATORY INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33417 (md)

29d. Date signed (Month, Day, Year)

July 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES R. MOEN, M.D. 1068 NATIONAL HWY LAVALE, MARYLAND 21502

31. Date filed (Month, Day, Year)

JUL 06 2000

32. Registrar's Signature

James R. Moen

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

nls

State  
Registrar



1000 0 0 1000

Certificate of Death

Reg. No.

00 23256

Physician  
/Medical  
Examiner

Funeral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles E. Bergman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. Date of Death<br>Month <b>July</b> Day <b>1</b> Year <b>2000</b>                                                                                                                              |  | 3. Time of Death<br><b>2135 PM</b>                                                                                                                                                                                                                                                          |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>                                                                                                                                        |  | 4c. County of Death<br><b>Washington</b>                                                                                                                                                                                                                                                    |  |
| 5. Social Security Number<br><b>216-18-1565</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                       |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.                                                                                                                                                                                                                                            |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Nov 3, 1922</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. County<br><b>Allegany</b>                                                                                                                                                                   |  | 10c. City, Town or Location<br><b>Cumberland</b>                                                                                                                                                                                                                                            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10e. Street and Number<br><b>520 Forester Avenue</b>                                                                                                                                             |  | 10f. Zip Code<br><b>21502</b>                                                                                                                                                                                                                                                               |  |
| 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>WW II</b>                                                                                                                               |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                          |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                                                                                                                                                                 |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>street dept laborer</b>                                                                                                                                                                                                                                                                                                                                                              |  | 16b. Kind of Business/Industry<br><b>City Cumberland</b>                                                                                                                                         |  | 17. Father's Name (First, Middle, Last)<br><b>Harry Bergman</b>                                                                                                                                                                                                                             |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude (nmn)</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda Stoner - Friend</b>                                                                                                                 |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13834 Clear Spring Rd; Clear Spring MD 21722</b>                                                                                                                                        |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SS Peter Paul Cemetery</b>                                                                                          |  | 20c. Location - City or Town, State<br><b>7/04/ Cumberland, MD</b>                                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br><b>James F. Scarpelli</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home, P.A.<br/>Cumberland, MD 21502</b>                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>10 hrs</b>                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC ENCEPHALOPATHY</b>                                                                                                                                                                                                                                                                                                                                              |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                        |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                           |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                             |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. Describe how injury occurred                                                                                                                                                                |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                         |  | 29b. Signature and title of certifier<br><b>Dr. J. Jones, MD</b>                                                                                                                                 |  | 29c. License number<br><b>D-40151</b>                                                                                                                                                                                                                                                       |  |
| 29d. Date signed (Month, Day, Year)<br><b>7/5/00</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 30. Name and Address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. J. Jones 249 Mill Street Hagerstown, Maryland</b>                                                 |  | 31. Date filed (Month, Day, Year)<br><b>JUL 07 2000</b>                                                                                                                                                                                                                                     |  |
| 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23257

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Frances Blanchard

2. Date of Death

Month Day Year  
July 8, 2000

3. Time of Death

22:55

4a. Facility Name (If not institution, give street and number)

Memorial Hospital &amp; Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

579-24-8648

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Jul 8, 1918

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

420 Race Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

12 Elementary/Secondary (0-12) 4 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Music Teacher

16b. Kind of Business/Industry

Teaching

17. Father's Name (First, Middle, Last)

Harvey Heckler

18. Mother's Name (First, Middle, Maiden Surname)

Mary A (Rooney)

19a. Informant's Name/Relationship (Type, Print)

Robert R. Blanchard  
husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

420 Race Street; Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

7/11/

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

Scarpelli's Funeral Home, P.A.

Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Approximate Interval Between Onset and Death

3 days

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Qamar Zaman

29c. License number

D0023371

29d. Date signed (Month, Day, Year)

July 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Qamar Zaman Johnson Heights Med Bldg 625 Kent Ave Ste 102 Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

Benjamin B Sparks

State  
Registrar

MARY BLANCHARD 579-24-8648

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Amended # 16A mzu  
07/10/00 Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23258

|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br>Margaret Blackburn                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |                                                    | 2. Date of Death<br>Month Day Year<br>July 1, 2000                                                                                                                                                                                                                                                      |                                                     | 3. Time of Death<br>12:20 A.M.                                                                     |                                                      |
|                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |                                                    | 4b. City, Town, or Location of Death<br>Cumberland                                                                                                                                                                                                                                                      |                                                     | 4c. County of Death<br>Allegany                                                                    |                                                      |
| Funeral<br>Director                                                                                                                                             | 5. Social Security Number<br>214-07-3957                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br>85 Yrs.          | If Under 1 Year<br>Months Days                                                                                                                                                                                                                                                                          | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth (Month, Day, Year)<br>Jan 5, 1915                                                 | 9. Birthplace (State or Foreign Country)<br>Maryland |
|                                                                                                                                                                 | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
| To Be Completed by Funeral Director                                                                                                                             | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. County<br>Allegany                                                                                                                               |                                                    | 10c. City, Town or Location<br>Cumberland                                                                                                                                                                                                                                                               |                                                     | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      |
|                                                                                                                                                                 | 10e. Street and Number<br>1 Baltimore St. Apt 415                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |                                                    | 10f. Zip Code<br>21502                                                                                                                                                                                                                                                                                  |                                                     | 10g. Citizen of What Country?<br>USA                                                               |                                                      |
|                                                                                                                                                                 | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                        |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                      |
|                                                                                                                                                                 | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>10                                                                                                                                                                                                                                                                                                                                                                                                 |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Celanese Worker (Spinner)                |                                                    | 16b. Kind of Business/Industry<br>Textile/Fiber                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
|                                                                                                                                                                 | 17. Father's Name (First, Middle, Last)<br>William Shipley                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jessie Neff                                                                                                                                                                                                                                        |                                                     |                                                                                                    |                                                      |
| To Be Completed by Physician/Medical Examiner                                                                                                                   | 19a. Informant's Name/Relationship (Type, Print)<br>Hallie Welch/Friend                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Brice Hollow Road, Cumberland, MD 21502                                                                                                                                                                |                                                     |                                                                                                    |                                                      |
|                                                                                                                                                                 | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                          |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery                                                          |                                                    | Date<br>July 5, 2000                                                                                                                                                                                                                                                                                    |                                                     | 20c. Location - City or Town, State<br>Cumberland, MD 21502                                        |                                                      |
|                                                                                                                                                                 | 21. Signature of Funeral Service Licensee<br><i>Douglas S. Hafer</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |                                                    | 22. Name and Address of Facility<br>Hafer Chapel of the Hills Mortuary<br>1302 National Hwy, LaVale, MD 21502                                                                                                                                                                                           |                                                     |                                                                                                    |                                                      |
|                                                                                                                                                                 | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Sepsis<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>24 hours<br>1 day |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
|                                                                                                                                                                 | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Coronary Artery Disease, Peripheral Vascular Disease,<br>Hypertension, Diabetes Mellitus                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
| State Registrar                                                                                                                                                 | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |                                                    | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                     |                                                                                                    |                                                      |
|                                                                                                                                                                 | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                   |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |                                                    | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                      |
|                                                                                                                                                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28d. Describe how injury occurred                                                                                                                     |                                                    |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
|                                                                                                                                                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
|                                                                                                                                                                 | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                            |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
| 29b. Signature and title of certifier<br><i>Huma Shakil MD</i>                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       | 29c. License number<br>D46346                      |                                                                                                                                                                                                                                                                                                         | 29d. Date signed (Month, Day, Year)<br>July 7, 2000 |                                                                                                    |                                                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Huma Shakil, Johnson Heights Medical Building, Cumberland, MD 21502 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |
| 31. Date filed (Month, Day, Year)<br>JUL 10 2000                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       | 32. Registrar's Signature<br><i>Huma B. Shakil</i> |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                      |

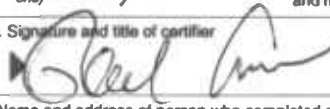
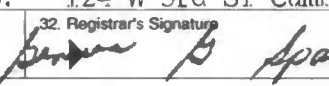




## Certificate of Death

Reg. No.

00 23259

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Lawrence Barry Lawrence Martin Barry</b>     |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>June 30 2000</b> |                                                                                             | 3. Time of Death<br><b>12:44 PM</b>                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>12714 Bedford Road</b> |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Cumberland</b> |                                                                                             | 4c. County of Death<br><b>Allegany</b>                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>215 34 4383</b>                                             |                                                                                                                                                                                                                                                                                                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.          |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>JULY 4 1937</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                 |                                                                                                                                                                                                                                                                                                        | 10a. State<br><b>MARYLAND</b>                                              |                                                                                                                                                                                              | 10b. County<br><b>ALLEGANY</b>                            |                                                                                             | 10c. City, Town or Location<br><b>CUMBERLAND</b>          |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             | 10e. Street and Number<br><b>12714 BEDFORD ROAD, NE</b>                                                                                                                                                                                                                                                |                                                                            | 10f. Zip Code<br><b>21502</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>U.S.</b>                                                |                                                           |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                            |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                      |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |                                                           |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CURING ROOM</b>                                                                                                                                                                        |                                                                            | 16b. Kind of Business/Industry<br><b>KELLY SPRINGFIELD TIRE</b>                                                                                                                              |                                                           |                                                                                             |                                                           |  |
| 17. Father's Name (First, Middle, Last)<br><b>LAWRENCE A. BARRY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MONICA ROONEY</b>                                                                                                                    |                                                           |                                                                                             |                                                           |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>BEVERLY CAROL BARRY / WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12714 BEDFORD ROAD, NE, CUMBERLAND, MD 21502</b>                                         |                                                           |                                                                                             |                                                           |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                     |                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. GEORGE'S EPISCOPAL CEM</b>                                                                                                                                                                                            |                                                                            | 20c. Location - City or Town, State<br><b>MT. SAVAGE, MD</b>                                                                                                                                 |                                                           | 20d. Date<br><b>7/3/00</b>                                                                  |                                                           |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                             | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A.<br/>60 W. MAIN ST., FROSTBURG, MD 21532</b>                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |  |
| 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Self inflicted gun shot wound to the head</b><br>Due to (or as a consequence of):<br><b>b. Major depression</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                            |                                                                            | 23c. Approximate Interval Between Onset and Death<br><b>sudden</b>                                                                                                                           |                                                           | 23d. Approximate Interval Between Onset and Death<br><b>6 months</b>                        |                                                           |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                     |                                                                            | 24c. Describe how injury occurred<br><b>subject shot himself</b>                                                                                                                             |                                                           |                                                                                             |                                                           |  |
| 24d. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>12714 Bedford Rd Cumb. MD</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                              |                                                                                             | 28a. Date of Injury (Month, Day, Year)<br><b>6/30/00</b>                                                                                                                                                                                                                                               |                                                                            | 28b. Time of Injury<br><b>noon</b> M                                                                                                                                                         |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                           |  |
| 28d. Date of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>residence</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             | 28e. Describe how injury occurred<br><b>subject shot himself</b>                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>12714 Bedford Rd Cumb. MD</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                              |                                                                                             | 29b. Signature and title of certifier<br><br><b>Dpty Med Ex</b>                                                                                                                                                     |                                                                            | 29c. License number<br><b>D 09157</b>                                                                                                                                                        |                                                           | 29d. Date signed (Month, Day, Year)<br><b>June 30 2000</b>                                  |                                                           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Snow, M.D. 124 W 3rd ST Cumb MD 21502</b>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 03 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             | 32. Registrar's Signature<br>                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit data.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23260

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Ann Broadwater

2. Date of Death

June 30, 2000

3. Time of Death

12:49 pm

4a. Facility Name (If not institution, give street and number)

Devlin Manor Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

214-05-8261

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 12, 1906

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

306 Fayette Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

George H. Rodenhauer, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Blanche (Sigler)

19a. Informant's Name/Relationship (Type, Print)

David Broadwater - grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

342 Dorn Avenue Cumberland MD 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

crematory, crematory or other place)

Scarpelli Funeral Home PA

Date

07/01

20c. Location - City or Town, State

Cresaptown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Scarpelli Funeral Home, PA  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Unknown

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36766

29d. Date signed (Month, Day, Year)

July 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vikramaditya Poonai 922 National Highway Cumberland MD 21502

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

*Handwritten signature*

1005/2 6 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23261

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carrie Lou Bobo

2. Date of Death

Month Day Year  
July 2, 2000

3. Time of Death

8:51 P.M.

4a. Facility Name (If not institution, give street and number)

560 Liberty Street

4b. City, Town, or Location of Death

Oakland,

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

235-32-7111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/11/1906

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

560 W. Liberty St.

10f. Zip Code

21550

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5th

Collage (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Coner

16b. Kind of Business/Industry  
Fiber Manufacture

17. Father's Name (First, Middle, Last)

Edward ----- CAYTON

18. Mother's Name (First, Middle, Maiden Surname)

Lou Bertie Propst

19a. Informant's Name/Relationship (Type, Print)

Priscilla D. Wolfe/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

560 W. Liberty St., Oakland, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Philos Cemetery

Date

7/6/00

20c. Location - City or Town, State

Westernport, MD

21. Signature of Funeral Service Licensee

Brodley A. Head

22. Name and Address of Facility

32 S. Second St.  
Oakland, MD 2155023a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral Infarction

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

26 Days

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicidal 4 ☐ Homicidal28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of certifier

Brodley A. Head

29c. License number

D0033464

29d. Date signed (Month, Day, Year)

July 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert M. Coughlin, M.D. PO Box 8, Eggleston, WV 26716

31. Date filed (Month, Day, Year)

JUL - 8 2000

32. Registrar's Signature

Brodley A. Head

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





00-3916-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

BARRY  
BOYCE

AMEND ITEMS: #23 PART I, 27, 28A-F, PER MEO G786 8-29-00 WR.00 23262

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br>BARRY JOHN BOYCE SR.                            |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               | 2. Date of Death<br>Month Day Year<br>JULY 15, 2000  |                                                                                                 | 3. Time of Death<br>12:30 P.M.                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br>1102 SOUTHERN KNIGHT LANE |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br>GAITHERSBURG |                                                                                                 | 4c. County of Death<br>MONTGOMERY                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br>219 64 6226                                                    |                                                                                                                                                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br>43 Yrs.            |                                                                                                 | 8. Date of Birth (Month, Day, Year)<br>OCT. 1, 1956 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 9. Birthplace (State or Foreign Country)<br>MARYLAND                                        |                                                                                                                                                        | 10e. State<br>MD.                                                          |                                                                                                                                                                                               | 10b. County<br>MONTGOMERY                            |                                                                                                 | 10c. City, Town or Location<br>GAITHERSBURG         |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             | 10f. Zip Code<br>20879                                                                                                                                 |                                                                            | 10g. Citizen of What Country?<br>UNITED STATES                                                                                                                                                |                                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                                     |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1974 |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                |                                                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>MANAGER                                    |                                                                            | 16b. Kind of Business/Industry<br>RETAIL TIRE STORE                                                                                                                                           |                                                      |                                                                                                 |                                                     |  |
| 17. Father's Name (First, Middle, Last)<br>ARTHUR HOWARD BOYCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                                                                                                                                        |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>JUNE LOIS KRATZ                                                                                                                          |                                                      |                                                                                                 |                                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>ARTHUR H. BOYCE, FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                        |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>114 MOMOSA AVENUE, COLONIAL BEACH, VA. 22443                                                 |                                                      |                                                                                                 |                                                     |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GEORGE WASHINGTON CEM.                                                       |                                                                            | 20c. Date<br>7/19/00                                                                                                                                                                          |                                                      | 20d. Location - City or Town, State<br>ADELPHI, MD.                                             |                                                     |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             | 22. Name and Address of Facility<br>MURIEL H. BARBER FUNERAL HOME<br>P.O. BOX 5038, LAYTONSVILLE, MD. 20882                                            |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>DOXEPIN AND ALCOHOL INTOXICATION<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) SCENE                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                       |                                                                                             | 28a. Date of Injury (Month, Day, Year)<br>Found: 7-15-00                                                                                               |                                                                            | 28b. Time of Injury<br>Found: At 12:15                                                                                                                                                        |                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                     |  |
| 28d. Describe how injury occurred<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>FOUND AT HOME                                                |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1102 SOUTHERN KNIGHT LN. GAITHERSBURG, MD                                                                     |                                                      |                                                                                                 |                                                     |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                       |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                                                                                                                        |                                                                            | 29c. License number<br>O.C.M.E.                                                                                                                                                               |                                                      | 29d. Date signed (Month, Day, Year)<br>JULY 16, 2000                                            |                                                     |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>MARGA MITA A. KOREN 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             | 32. Registrar's Signature<br>                                                                                                                          |                                                                            |                                                                                                                                                                                               |                                                      |                                                                                                 |                                                     |  |

ORIGINAL



Amended # 11 mv  
Allegany Co 07/10/00

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State of Maryland / Department of Health and Mental Hygiene 00 23263

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br>Ruth Alberta Carey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>JULY 9 2000                                                                                                                                                   |  |                                                                                      |  | 3. Time of Death<br>4:20 AM                                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br>220 Somerville Avenue Apt. 608                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Cumberland                                                                                                                                                  |  |                                                                                      |  | 4c. County of Death<br>Allegany                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br>577-48-9229                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>66 Yrs.                                                                                                                                                           |  | 8. Date of Birth (Month, Day, Year)<br>Jul 5, 1934                                   |  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                               | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         | 10b. County<br>Allegany                                                                                                                                                                                                                                                                                 |  | 10c. City, Town or Location<br>Cumberland                                                                                                                                                           |  |                                                                                      |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                   | 10e. Street and Number<br>220 Somerville Avenue Apt. 608                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br>21502                                                                                                                                                                              |  | 10g. Citizen of What Country?<br>USA                                                 |  |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                              |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify white                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | 15. Decedent's Education (Specify only highest grade completed)<br>1 <input type="checkbox"/> Elementary/Secondary (0-12) 2 <input checked="" type="checkbox"/> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Home Health Care Aid                                                                                                                                                                       |  |                                                                                                                                                                                                     |  | 16b. Kind of Business/Industry<br>Health Care                                        |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                     | 17. Father's Name (First, Middle, Last)<br>Edward Albert Carey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ruth V (Simons)                                                                                                                                |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | 19a. Informant's Name (Relationship (Type, Print)<br>James M. Nixon son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>220 Somerville Ave 608, Cumberland, MD 21502                                                       |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Scarpelli Funeral Home                                                                                                                                                                                                        |  | Date<br>7/09/                                                                                                                                                                                       |  | 20c. Location - City or Town, State<br>Cresaptown, MD                                |  |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | 21. Signature of Funeral Service Licensee<br>Nicholas J. Scarpelli                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         |                                                                                                                                                                                                                                                                                                         |  | 21a. Address of Funeral Home<br>Scarpelli Funeral Home P.A.<br>Cumberland, Maryland 21502                                                                                                           |  |                                                                                      |  |                                                                                                                                                                                                          |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                 | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Endstage Nonhodgkins Lymphoma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                         |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  | Approximate Interval Between Onset and Death<br>6 mos                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                  |                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M                                                                                                                                                                            |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  |                                                                                                                                                                                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                           |                                         |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |
| State<br>Registrar                                                                                                                                                                                                                                                                                                                                | 29b. Signature and title of certifier<br>D. Wagoner MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         |                                                                                                                                                                                                                                                                                                         |  | 29c. License number<br>D22181                                                                                                                                                                       |  | 29d. Date signed (Month, Day, Year)<br>JULY 09 2000                                  |  |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gary Wagoner M.D. Bishop Walsh Drive Cumberland MD 21502                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 2000                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 32. Registrar's Signature<br>D. Wagoner |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |

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Amended # 29 d mlu  
Allegany Co 07/11/00

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23264

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br>Beulah Mae Cutter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br>JULY 8 2000                                                                                                                                             |                                                                                                                                                    | 3. Time of Death<br>7:00 AM                                                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br>Sacred Heart Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br>Cumberland                                                                                                |                                                                                                                                                                                               | 4c. County of Death<br>Allegany                                                                                                                    |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br>215-42-4263                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                    | 7. Age (In yrs. last birthday)<br>84 Yrs.                                                                                                                                                                                                                                                   | If Under 1 Year<br>Months Days                                                                                                                    | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br>August 6, 1915                                                                                              |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br>Allegany                                                                       |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br>Frostburg                                                                                                          |                                                                                                                                                                                               | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                     |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br>20516 Hersick Rd., S.W.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br>21532                                                                                                                            |                                                                                                                                                                                               | 10g. Citizen of What Country?<br>USA                                                                                                               |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3 College (14 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                      |                                                                                                                                                   |                                                                                                                                                                                               | 16b. Kind of Business/Industry<br>Home                                                                                                             |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br>Floyd Bittinger                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Gilpin                                                                                  |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Larna Dawson-Daughter                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12114 Vale Summit Rd. S.W., Frostburg, Md. 21532 |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Frostburg Mem. Park |                                                                                                                                                                                                                                                                                             | Date<br>July 10, 2000                                                                                                                             |                                                                                                                                                                                               | 20c. Location - City or Town, State<br>Frostburg, Md.                                                                                              |                                                                                                                                                                                                  |  |
| 21. Signature of Funeral Service Licensee<br><i>James E. McKenzie</i>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                             | 22. Name and Address of Facility<br>Eichhorn-McKenzie Funeral Home P.A.<br>Lonaconing, Md. 21539                                                  |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. SEASIS<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    | Approximate Interval Between Onset and Death<br>Four days                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CARCINOMA COLON, ALZHEIMER DEMENTIA<br>RENAL FAILURE HYPOTHYROIDISM<br>DIABETES MELLITUS                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                      | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br>M                                                                                                                                                                      |                                                                                                                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                        |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br><i>James E. McKenzie</i>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                             | 29c. License number<br>D 26907                                                                                                                    |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br>JULY 8 2000                                                                                                 |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Harjit Sidhu M.D. 925 Bishop Walsh Road Cumberland MD 21502                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| State<br>Registrar                                                                                                                                                                                                                                                                                                                                                                                                        | 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               | 32. Registrar's Signature<br><i>James E. McKenzie</i>                                                                                                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-6000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

mv 3 / mv 3

2000 1 1 JUL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23265

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>HAZEL RUTH DAVIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 12, 2000</b>                                                                                                                                       |                                                                         | 3. Time of Death<br><b>1:12 AM</b>                                                             |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>235 COLUMBIA STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>                                                                                                                                        |                                                                         | 4c. County of Death<br><b>ALLEGANY</b>                                                         |                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>215-20-7479</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                         |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                                                                                                                                                                                                                                            |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>APR. 16, 1927</b>             |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>CUMBERLAND</b>                                                                                                                                                 |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. County<br><b>ALLEGANY</b>                                                                                                                     |  | 10e. Street and Number<br><b>235 COLUMBIA STREET</b>                                                                                                                                                                                                                                        |                                                                                                                                                                                                  | 10f. Zip Code<br><b>21502</b>                                           |                                                                                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                             |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                                                                |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CUSTODIAN &amp; CROSSING GUARD</b> |  | 16b. Kind of Business/Industry<br><b>CITY OF CUMBERLAND</b>                                                                                                                                                                                                                                 |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>WALTER R. GORDON, SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIRGINIA IMES</b>                                                                                                                        |                                                                         |                                                                                                |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>WILLIAM R. DAVIS, JR. / SON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>235 COLUMBIA STREET, CUMBERLAND, MD 21502</b>                                                |                                                                         |                                                                                                |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MSVC-ROCKY GAP</b>                                                    |  | Date<br><b>7/14/00</b>                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                  | 20c. Location - City or Town, State<br><b>FLINTSTONE, MD</b>            |                                                                                                |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br><b>S. Mark Sapp</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | 22. Name and Address of Facility<br><b>UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial infarction</b><br>Due to (or as a consequence of):<br><b>b. arteriosclerosis</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Dilated cardiomyopathy, Hypertension</b> |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | Approximate Interval Between Onset and Death<br><b>1 day</b><br><b>5 years</b>                                                                                                                   |                                                                         |                                                                                                |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dilated cardiomyopathy, Hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                         |                                                                                                |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                         |                                                                                                |                                                                                  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>released</b>                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                                                                  | 28b. Time of Injury<br><b>M</b>                                         |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  | 29b. Signature and title of certifier<br><b>George M. Breza MD</b>                                                                                                                                                                                                                          |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
| 29c. License number<br><b>D12532</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br><b>7/13/2000</b>                                                                                                                                                                                                                                     |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GEORGE M. BREZA 912 SETON DR., CUMBERLAND, MD 21502</b>                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 13 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  | 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>                                                                                                                                                                                                                                      |                                                                                                                                                                                                  |                                                                         |                                                                                                |                                                                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

M.E. Notified & Released  
Medical Certification: To Be Completed by Physician/Medical Examiner

mv  
7



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23266

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY J. EVANS

2. Date of Death  
Month Day Year  
JUNE 30 20003. Time of Death  
12:25AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

AVALON MANOR HEALTH CARE CENTER

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

214-07-6411

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 19 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Md.

10b. County

WASHINGTON

10c. City, Town or Location

HAGERSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14014 MARSH PIKE

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

BLUFORD

GENTRY

18. Mother's Name (First, Middle, Maiden Surname)

EDNA

FRANKENBERRY

19a. Informant's Name/Relationship (Type, Print)

DENNIS G. EVANS, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13620 PARADISE DRIVE HAGERSTOWN MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METHODIST CEMETERY 7/3/2000 MT.SAVAGE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DURST FUNERAL HOME P.A.  
57 FROST AVENUE FROSTBURG, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertension Cardiovascular disease  
Due to (or as a consequence of):b.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18019

29d. Date signed (Month, Day, Year)

JUNE 30, 2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. Vasant Datta 334 Mill Street, Hagerstown, MD 21740

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

ORIGINAL

DOROTHY EVANS 6-30-00 TIME OF DEATH 12:25A

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5053.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3  
MS

Handwritten text, possibly a signature or initials.

0005 2 0 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23267

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES LEO FURSTENBERG JR.

2. Date of Death

Month Day Year

JULY 13 2000

3. Time of Death

5:41AM

4a. Facility Name (If not institution, give street and number)

213 CARROLL STREET

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

212-54-8251

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUGUST 3 1949

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

213 CARROLL STREET

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1968-1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CITY OF CUMBERLAND/STREET DEPT

16b. Kind of Business/Industry

STREET DEPT.

17. Father's Name (First, Middle, Last)

JAMES LEO FURSTENBERG SR

18. Mother's Name (First, Middle, Maiden Surname)

BARBARA MAE WAYS

19a. Informant's Name/Relationship (Type, Print)

LINDA FURSTENBERG

WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 CARROLL STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILLCREST CEMETERY JULY 15 2000

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Wale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME P.A.

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Glioblastoma multiforme

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

9 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicida 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 0054426

29d. Date signed (Month, Day, Year)

JULY 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MICHAEL D. ZANG 500 MEMORIAL AVE CUMBERLAND MARYLAND 21502

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2028.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

(1/4) mv 12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23268

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RITA VIRGINIA FARRIN

2. Date of Death

Month Day Year  
July 13, 2000

3. Time of Death

5:40 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

214-07-4530

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 5 1915

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1506 C OLDTOWNE MANOR

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

HOME MAKER

17. Father's Name (First, Middle, Last)

ANTHONY MOLINARI

18. Mother's Name (First, Middle, Maiden Surname)

ODESSA CULP

19a. Informant's Name/Relationship (Type, Print)

ANTHONY MOLINARI

BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RFD# 3 BOX# 52 RIDGELEY WEST VIRGINIA 26753

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SUNSET CEMETERY JULY 15 2000

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME P.A.

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Bilateral Pneumonia

Due to (or as a consequence of):

2 weeks

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis of Liver

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Sunil Gupta

29c. License number

D33280

29d. Date signed (Month, Day, Year)

July 13, 2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. Sunil Gupta, Johnson Heights Medical Bldg., Cumberland, MD 21502

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Diana B Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23269

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>William W. Flanagan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 2. Date of Death<br>Month Day Year<br><b>July 11, 2000</b>                                                                                                                                   |                                                                                                | 3. Time of Death<br><b>11:12 pm</b>                                                                                                                |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>16111 Maple Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 4b. City, Town, or Location of Death<br><b>Rawlings</b>                                                                                                                                      |                                                                                                | 4c. County of Death<br><b>Allegany</b>                                                                                                             |                                                                                                                                                                                                  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>214-34-1930</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>Oct 11, 1934</b>                                     |                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><b>Allegany</b>                                                                                                                                                                                                                                                              | 10c. City, Town or Location<br><b>Rawlings</b>                                                                                                    |                                      |                                                                                                                                                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                    |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>16111 Maple Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 10f. Zip Code<br><b>21557</b>        |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                                                                                                    |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                            |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b>                   |                                      |                                                                                                                                                                                              | 16b. Kind of Business/Industry<br><b>School</b>                                                |                                                                                                                                                    |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>Glen Flanagan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mabel (Grogg)</b>                                                                                                                    |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>John Flanagan son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 311; Rawlings MD 21557</b>                                                      |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Abe Cemetery</b>                                                     |                                      | Data<br><b>7/14/</b>                                                                                                                                                                         | 20c. Location - City or Town, State<br><b>Short Gap, WV</b>                                    |                                                                                                                                                    |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br><b>James F. Scarcell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 22. Name and Address of Facility<br><b>Scarcell Funeral Home, P.A.<br/>Cumberland, MD 21502</b>                                                                                              |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. COLON CANCER</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                    | Approximate Interval Between Onset and Death<br><b>18 months</b>                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                              |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                      |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>      |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                                                                                                                    | 28d. Describe how injury occurred                                                                                                                                                                |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 29b. Signature and title of certifier<br><b>Physician</b>                                                                                                                                                                                                                                   |                                                                                                                                                   | 29c. License number<br><b>D50844</b> |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>July 12, 2000</b>                                    |                                                                                                                                                    |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Jose Loveria, M.D., 912 Seton Drive; Cumberland, MD 21502</b>                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                              | 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             | 32. Registrar's Signature<br><b>James B. Sparks</b>                                                                                               |                                      |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23270

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                    |  |                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Janet Allison Fisher</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                    |  | 2. Date of Death<br>Month Day Year<br><b>Jun 28, 2000</b>                                                                                                                                                                 |  | 3. Time of Death<br><b>09:10am</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Lions Manor Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                    |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                                                                                                                                                                 |  | 4c. County of Death<br><b>Allegany</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>017-01-4770</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                         |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                                                                                                          |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 3, 1919</b>                                                                                                                                                                                                                                                                                                                                                                 |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>MA</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10a. State<br><b>MD</b>                                                                                                                            |  | 10b. County<br><b>Allegany</b>                                                                                                                                                                                            |  | 10c. City, Town or Location<br><b>Flintstone</b>                                                                                                                                                                                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  |  | 10e. Street and Number<br><b>11200 Cresap Mill Road SE</b>                                                                                         |  | 10f. Zip Code<br><b>21530</b>                                                                                                                                                                                             |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                               |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                              |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                     |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>payroll clerk</b>                  |  | 16b. Kind of Business/Industry<br><b>retail</b>                                                                                                                                                                           |  | 17. Father's Name (First, Middle, Last)<br><b>Douglas Leslie</b>                                                                                                                                                                                                                                                                                                                                                          |  |
|                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Janet (Jackson)</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Tom Reilly</b>                                                                              |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>526 Gleanings Drive; McHenry, MD 21541</b>                                                                            |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadow Rdg Mem Park</b>                                                                                                                                                                                                                                                                                                                                                            |  | 20c. Location - City or Town, State<br><b>Elkridge, MD</b>                                                                                         |  | 21. Signature of Funeral Service Licensee<br><b>James F Scarpelli</b>                                                                                                                                                     |  | 22. Name and Address of Facility<br><b>Scarpelli FH PA for Gary L Kaufman FH<br/>Cumberland, Maryland 21502</b>                                                                                                                                                                                                                                                                                                           |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac arrhythmia</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>&lt; 1 hour</b>                                                                                 |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Metastatic Lung Cancer, Anorexia<br/>Try to Ca, COPD, Alzheimer's disease<br/>depression</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                           |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                         |  | 28a. Date of Injury (Month, Day Year)                                                                                                              |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                           |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                             |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                              |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|                                               | 29b. Signature and title of certifier<br><b>V. A. Ranjithan</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 29c. License number<br><b>D19750</b>                                                                                                               |  | 29d. Date signed (Month, Day, Year)<br><b>June 29, 2000</b>                                                                                                                                                               |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>V.A. Ranjithan, M.D.; Lions Manor Nursing Home, Seton Dr Ext. Cumberland, MD 21502</b>                                                                                                                                                                                                                                         |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 32. Registrar's Signature<br><b>Benjamin B Sparks</b>                                                                                              |  |                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |

Handwritten signature or mark

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State of Maryland / Department of Health and Mental Hygiene

00 23271

## Certificate of Death

Reg. No.

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                        | 1. Decedent's Name (First, Middle, Last)<br><b>SHERMAN LEROY FRIEND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month Day Year<br><b>JUNE 30, 2000</b>                                                                                                                                    |  |                                                                                             |                                                                                                                                                                                                  | 3. Time of Death<br><b>1:08 PM</b>                                                             |  |                                                                                                |  |
|                                                          | 4a. Facility Name (If not institution, give street and number)<br><b>GARRETT COUNTY MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>OAKLAND</b>                                                                                                                                        |  |                                                                                             |                                                                                                                                                                                                  | 4c. County of Death<br><b>GARRETT</b>                                                          |  |                                                                                                |  |
| Funeral<br>Director                                      | 5. Social Security Number<br><b>212-24-0029</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.                                                                                                                                              |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT 15 1927</b>                                  |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |  |                                                                                                |  |
|                                                          | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
| To Be Completed by Funeral Director                      | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   | 10b. County<br><b>GARRETT</b>                                                                                                                                                                                                                                                               |  | 10c. City, Town or Location<br><b>SWANTON</b>                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                                                                                |  |
|                                                          | 10e. Street and Number<br><b>7875 MARYLAND HIGHWAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>21561</b>                                                                                                                                                                 |  | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
|                                                          | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>KOREA</b>                                                                                                                              |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                          |                                                                                                |  |                                                                                                |  |
|                                                          | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>CARMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARMAN</b>                                                                    |  |                                                                                             | 16b. Kind of Business/Industry<br><b>RAILROAD</b>                                                                                                                                                |                                                                                                |  |                                                                                                |  |
|                                                          | 17. Father's Name (First, Middle, Last)<br><b>SHERMAN BRUCE FRIEND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DELLA ALBERTA REXRODE</b>                                                                                                             |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
| To Be Completed by Physician/Medical Examiner            | 19a. Informant's Name/Relationship (Type, Print)<br><b>HELEN FRIEND - WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7875 MARYLAND HWY. SWANTON, MARYLAND 21561</b>                                            |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
|                                                          | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GEORGE CEMETERY</b>                                                                                                                                                                                            |  | Date<br><b>7/3/00</b>                                                                                                                                                                         |  | 20c. Location - City or Town, State<br><b>SWANTON, MARYLAND</b>                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
|                                                          | 21. Signature of Funeral Service Licensee<br> <b>MO0167</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>P.O. BOX 243 DURS FUNERAL HOME - OAKLAND, MD 21550</b>                                                                                                 |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
|                                                          | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>tension pneumothorax</b><br>Due to (or as a consequence of):<br>b. <b>pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>emphysema</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  | Approximate Interval Between Onset and Death<br><b>5 mins</b><br><b>2 wks.</b><br><b>years</b> |  |
|                                                          | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>renal failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                                                |  |                                                                                                |  |
| State Registrar                                          | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
|                                                          | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  | 28d. Describe how injury occurred                                                              |  |                                                                                                |  |
|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                                                                                                                                                                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
|                                                          | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                         |                                                                                                                   | 29b. Signature and title of certifier<br>                                                                                                                                                                |  | 29c. License number<br><b>D23979</b>                                                                                                                                                          |  | 29d. Date signed (Month, Day, Year)<br><b>07-06-00</b>                                      |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
|                                                          | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Robert A. Goralski, Garrett Medical Group, 311 N. 4th St., Oakland, MD 21550</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                   |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL - 6 2000</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                                                                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit






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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23272

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|--|--|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH RUSSELL GOODFELLOW</b>                                    |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 10, 2000</b> |                                                                                             | 3. Time of Death<br><b>6:50 a.m.</b>                                                                                                                                                             |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital &amp; Medical Center</b> |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |                                                                                             | 4c. County of Death<br><b>Allegany</b>                                                                                                                                                           |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>220-10-1142</b>                                                                 |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.                                                                                                                                             |                                                            | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 30, 1910</b>                                 |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>       |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                     |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 10a. State<br><b>WV</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                 | 10b. County<br><b>HAMPSHIRE</b> |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>SPRINGFIELD</b>                                                                             |                                                                                                                                                                                              |                                                            |                                                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 10e. Street and Number<br><b>BOX 163</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>26763</b>                                                                                                 |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>U.S.A.</b>             |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                 |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                            |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                          |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARPENTER</b> |                                                                                                                                                                                              |                                                            | 16b. Kind of Business/Industry<br><b>CARPENTRY</b>                                          |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOSEPH RUSSELL GOODFELLOW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FLORENCE MILLER</b>                                                                                                                  |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ESTHER M. GOODFELLOW / WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>BOX 163, SPRINGFIELD, WV 26763</b>                                                       |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CUMBERLAND CREMATORY</b>                                                                                                                                                                                       |                                                                                                                               | Date<br><b>7/11/00</b>                                                                                                                                                                       |                                                            | 20c. Location - City or Town, State<br><b>CUMBERLAND, MD</b>                                |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 22. Name and Address of Facility<br><b>UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td colspan="8">           a. <b>Aspiration Pneumonia</b><br/>Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>3 days</b> </td> </tr> <tr> <td colspan="8">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">d. Due to (or as a consequence of):</td> </tr> </table> |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of): |  |  |  |  |  |  |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br><br><b>3 days</b> | b. Due to (or as a consequence of):                                                                   |  |  |  |  |  |  |  | c. Due to (or as a consequence of):                                                                                                                |  |  |  |  |  |  |  | d. Due to (or as a consequence of): |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | a. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):                                              |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br><br><b>3 days</b> |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | b. Due to (or as a consequence of):                                                                             |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | c. Due to (or as a consequence of):                                                                             |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | d. Due to (or as a consequence of):                                                                             |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| <table border="1"> <tr> <td colspan="8"> <b>Coronary Artery Disease</b> </td> <td colspan="2">           23b. Did tobacco use contribute to the cause of death?<br/> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown         </td> </tr> <tr> <td colspan="8">           24a. Was an autopsy performed?<br/> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> <td colspan="2">           24b. Were autopsy findings available prior to completion of cause of death?<br/> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> </tr> </table>                                                            |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   | <b>Coronary Artery Disease</b>                                                                                                                                                                                                    |                                                                    |  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| <b>Coronary Artery Disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                 |                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                 |                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                               | 28b. Time of Injury<br>M                                                                                                                                                                     |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  | 28d. Describe how injury occurred                                 |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 |                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                               |                                                                                                                                                                                              |                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                                     |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 29c. License number<br><b>D0014865</b>                                                                                                                                                       |                                                            | 29d. Date signed (Month, Day, Year)<br><b>July 10<sup>th</sup>, 2000</b>                    |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Robustiano J. Barrera 500 Memorial Avenue Suite 201 Cumberland, MD 21502</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 |                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 13 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                 |                                 | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                                                                               |                                                                                                                                                                                              |                                                            |                                                                                             |                                                                                                                                                                                                  |                                                                   |                                                                                                                                                                                                                                   |                                                                    |  |  |  |  |  |  |                                                                                                                                                                                                  |                                                                   |                                                                                                       |  |  |  |  |  |  |  |                                                                                                                                                    |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

35

State  
Registrar

Handwritten signature and date: 1905 JUL 30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23273

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                         |                                                                                                                                                                                                  |                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><b>BEULAH LOUISE GLOTFELTY</b>                       |                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>JUNE 27 2000</b> |                                                                                             |                                                                         |                                                                                                                                                                                                  | 3. Time of Death<br><b>09:15AM</b>    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br><b>3452 WILLIAMSBURG DRIVE</b> |                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>WALDORF</b>    |                                                                                             |                                                                         |                                                                                                                                                                                                  | 4c. County of Death<br><b>CHARLES</b> |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br><b>160-20-9944</b>                                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                        | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth (Month, Day, Year)<br><b>MAY 12 1924</b>                                   |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                                                                                                                                            |                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Usual Residence of Decedent                                                                      |                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 10a. State<br><b>PA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  | 10b. County<br><b>BEDFORD</b>                                                                                                                                                                                                                                                                                     |                                                  | 10c. City, Town or Location<br><b>EVERETT</b>                                                                                                                                                |                                                           |                                                                                             |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                       |  |
| 10a. Street and Number<br><b>426 EAST MAIN STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  | 10f. Zip Code<br><b>15537</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                 |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                                                                                                                                                                  |                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                                                                |                                                           |                                                                                             | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                       |                                                                                                                                                                                                  |                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>WEBSTER MILLER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AMANDA MILLER</b>                                                                                                                    |                                                           |                                                                                             |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CONNIE L. AKERS / DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3452 WILLIAMSBURG DRIVE, WALDORF, MD 20601</b>                                           |                                                           |                                                                                             |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>EVERETT CEMETERY</b>                                                                                                                                                                                                                 |                                                  | Date<br><b>7/1/00</b>                                                                                                                                                                        |                                                           | 20c. Location - City or Town, State<br><b>EVERETT, PA</b>                                   |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  | 22. Name and Address of Facility<br><b>DALLA VALLE F.S.I., 22 WEST MAIN STREET<br/>EVERETT, PA 15537</b>                                                                                     |                                                           |                                                                                             |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>COLON CANCER</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                         | Approximate Interval Between Onset and Death<br><b>YEARS</b>                                                                                                                                     |                                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEEP VEIN THROMBOSES</b><br><b>CONGESTIVE HEART FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                       |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |                                       |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>DAUGHTERS HOME</b> |                                                  |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                            |                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                                                                                                                                |                                       |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                    |                                                                                                  | 29b. Signature and title of certifier<br>                                                                                                                                                                                      |                                                  | 29c. License number<br><b>D46419</b>                                                                                                                                                         |                                                           | 29d. Date signed (Month, Day, Year)<br><b>JUNE 27 2000</b>                                  |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHARLENE LETCHFORD, MD., 404 EAST CHARLES STREET, LA PLATA, MD 20646</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                         |                                                                                                                                                                                                  |                                       |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 13 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  | 32. Registrar's Signature<br>                                                                                                                                                                                                 |                                                  |                                                                                                                                                                                              |                                                           |                                                                                             |                                                                         |                                                                                                                                                                                                  |                                       |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-3000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

376



Certificate of Death

Reg. No.

00 23274

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

Physician  
/Medical  
Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Sandra Kay Hutt</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 2. Date of Death<br>Month <b>Jul</b> Day <b>4</b> Year <b>2000</b>                                                                                                                                                                                                                          |  | 3. Time of Death<br><b>07:10am</b>                                                                                                                                                           |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Devlin Manor Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                                                                                                                                                                                                                                   |  | 4c. County of Death<br><b>Allegany</b>                                                                                                                                                       |  |
| 5. Social Security Number<br><b>213-44-1752</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.                                                                                                                                             |  |
| 8. Date of Birth (Month, Day, Year)<br><b>May 8, 1945</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                       |  |                                                                                                                                                                                              |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 10e. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. County<br><b>Allegany</b>                                                                                                                                                                                                                                                              |  | 10c. City, Town or Location<br><b>Cumberland</b>                                                                                                                                             |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 10e. Street and Number<br><b>15 West Second Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10f. Zip Code<br><b>21502</b>                                                                                                                                                                                                                                                               |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (0-12) <b>College (1-4or 5+)</b>                                                                                                                                                          |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>employee Clerk</b>                                                           |  |
| 16b. Kind of Business/Industry<br><b>Department Store</b><br><del>Sears Roebuck Co</del>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 17. Father's Name (First, Middle, Last)<br><b>Leroy Ritz</b>                                                                                                                                                                                                                                |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella (Grimm)</b>                                                                                                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Hutt</b><br><b>husband</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15 West Second Street ;Cumberland, MD21502</b>                                                                                                                                          |  |                                                                                                                                                                                              |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hillcrest Memorial Par7/07/ Cumberland, MD</b>                                                                                                                                                                 |  | 20c. Location - City or Town, State                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br><b>James F. Scarpelli</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22. Name and Address of Facility<br><b>Scarpeilli Funeral Home P.A.</b><br><b>Cumberland, Maryland 21502</b>                                                                                                                                                                                |  |                                                                                                                                                                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Breast Cancer, metastatic</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>2 yr</b> |  | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):                                                                                                                                    |  | Approximate Interval Between Onset and Death                                                                                                                                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                              |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                             |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                       |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 29b. Signature and title of certifier<br><b>Anthony Bollino</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 29c. License number<br><b>D17565</b>                                                                                                                                                                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>Jul 5, 2000</b>                                                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anthony Bollino 922 National Highway LaVale MD 21502</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. Registrar's Signature<br><b>James B. Sparks</b>                                                                                                                                                                                                                                         |  |                                                                                                                                                                                              |  |

July 30 1900



Amended #16a, 26, NLS,  
7/6/00, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23275

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas C. Humbertson

2. Date of Death  
Month Day Year

July 2, 2000

3. Time of Death

16:11PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

219-14-7444

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

74

8. Date of Birth (Month, Day, Year)

Jun 24, 1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Oldtown

10d. Inside City Limits  
☐ Yes ☒ No

10e. Street and Number

17705 Olive Beltz Road

10f. Zip Code

21555

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

☒ Yes ☐ No  
If Yes, Give  
Year or Dates

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

retired laborer

16b. Kind of Business/Industry

Brewery

17. Father's Name (First, Middle, Last)

George Humbertson

18. Mother's Name (First, Middle, Maiden Surname)

Annie (Seib)

19a. Informant's Name/Relationship (Type, Print)

Edith A. Humbertson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17705 Olive Beltz Road; Oldtown MD 21555

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Restlawn Memorial Gard

Date

7/06/

20c. Location - City or Town, State

LaVale, MD

21. Signature of Funeral Service Licensee

James J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Myocardial infarction

Due to (or as a consequence of)

b.

arteriosclerosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Approximate  
Interval Between  
Onset and Death

1 day

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Polyphemia, secondary

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy  
performed?

☐ Yes ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

☐ Yes ☐ No

25. Was case referred to medical  
examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☒ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

28c. Injury at  
Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. George Breza

29c. License number

D12532

29d. Date signed (Month, Day, Year)

7/5/2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. George Breza

912 Seton Drive

Cumberland MD 21502

31. Date filed (Month, Day, Year)

JUL 06 2000

32. Registrar's Signature

James J. Scarpelli

State  
Registrar



Handwritten signature or scribble

1000 0 0 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23276

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----------------------------------------------|--|--|--|--|--|--|--|----|----------------------------------|--|--|--|--|--|--|--|----|----------------------------------|--|--|--|--|--|--|--|----|----------------------------------|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br><i>Charles Harvey Hyde</i>                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               | 2. Date of Death<br>Month <i>July</i> Day <i>10</i> Year <i>2000</i> |                                                                                                | 3. Time of Death<br><i>10:50 AM</i>                                     |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4a. Facility Name (If not institution, give street and number)<br><i>GOOD SAMARITAN NURSING CENTER</i> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><i>BALTIMORE</i>             |                                                                                                | 4c. County of Death<br><i>BALTIMORE</i>                                 |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br><i>214-05-7222</i>                                                        |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                         |                                                                                                                                         | 7. Age (In yrs. last birthday)<br><i>87</i> Yrs.                                                                                                   |                                                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><i>SEPT 7 1912</i>            |                                                                                                | 9. Birthplace (State or Foreign Country)<br><i>MARYLAND</i>             |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Usual Residence of Decedent                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 10a. State<br><i>MARYLAND</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | 10b. County<br><i>ALLEGANY</i>                                                                                                                                                                                                                                                              |                                                                                                                                                                    | 10c. City, Town or Location<br><i>CUMBERLAND</i>                                                                                        |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 10e. Street and Number<br><i>502 MARYLAND AVENUE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    | 10f. Zip Code<br><i>21502</i>                                                                                                                                                                 |                                                                      | 10g. Citizen of What Country?<br><i>U.S.A.</i>                                                 |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>1943-1946</i> |                                                                                                                                         |                                                                                                                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>WHITE</i> |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>1</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>COMPTROLLER OF BANK</i> |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      | 16b. Kind of Business/Industry<br><i>BANKING</i>                                               |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>HARVEY E. HYDE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>FLORA BURKET</i>                                                                                                                      |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>CHARLYNNE M. DWELLEY DAUGHTER</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2528 GLENCOE ROAD BALTIMORE MD. 21234</i>                                                 |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>EMTOMBMENT</i>                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>ROSE HILL MAUSOLEUM</i>                                                               |                                                                                                                                         |                                                                                                                                                    | 20c. Date<br><i>JULY 14 2000</i>                                                                                                                                                              |                                                                      | 20d. Location - City or Town, State<br><i>CUMBERLAND MARYLAND</i>                              |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Dale L. Merritt</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    | 22. Name and Address of Facility<br><i>MERRITT-ADAMS FUNERAL HOME P.A.<br/>404 DECATUR STREET CUMBERLAND MARYLAND</i>                                                                         |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td colspan="8"><i>Recurrent Aspiration Pneumonia / Month</i></td> </tr> <tr> <td>b.</td> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="8">Due to (or as a consequence of):</td> </tr> </table> |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <i>Recurrent Aspiration Pneumonia / Month</i> |  |  |  |  |  |  |  | b. | Due to (or as a consequence of): |  |  |  |  |  |  |  | c. | Due to (or as a consequence of): |  |  |  |  |  |  |  | d. | Due to (or as a consequence of): |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                    | a.                                                                                                     | <i>Recurrent Aspiration Pneumonia / Month</i>                                                                                                                                                                                                                                               |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | b.                                                                                                     | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | c.                                                                                                     | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | d.                                                                                                     | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Alzheimer's disease</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                                    | 28b. Time of Injury<br><i>M</i>                                                                                                         |                                                                                                                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                                      | 28d. Describe how injury occurred                                                              |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                            |                                                                                                        | 29b. Signature and title of certifier<br><i>Suresh Tripathi</i>                                                                                                                                                                                                                             |                                                                                                                                                                    | 29c. License number<br><i>D30661</i>                                                                                                    |                                                                                                                                                    | 29d. Date signed (Month, Day, Year)<br><i>July 10th 2000</i>                                                                                                                                  |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Suresh TRIPATHI<br/>5601 Loch Raven Blvd, Baltimore, Md - 21239</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 11 2000</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | 32. Registrar's Signature<br><i>Berna B Sparks</i>                                                                                                                                                                                                                                          |                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                    |                                                                                                                                                                                               |                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                                                   |    |                                               |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23277

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BARBARA J. HAINES

2. Date of Death

June 26, 2000

3. Time of Death

1:20 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

232-36-9103

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 23, 1929

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 3, Box 3208

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Andrew Landes

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Opal Fleming

19a. Informant's Name/Relationship (Type, Print)

R. Guy Haines/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 3, Box 3208 Keyser, WV 26726

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Potomac Memorial Gardens

Date

June 29  
2000

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

Brian F. Smith

22. Name and Address of Facility

Smith Funeral Home

85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sarcoidosis, hypothyroidism, steroid-induced myopathy,

atrial flutter

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Boyd Sprenkle

29c. License number

D 54946

29d. Date signed (Month, Day, Year)

July 06, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Boyd Sprenkle, Memorial Hospital, Suite 400, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "JUL 1 1965".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23278

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER RUSSELL HENSEL

2. Date of Death

Month Day Year  
July 10, 2000

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY, MD

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

232-26-7937

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 18 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13905 WINCHESTER ROAD S.W.

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1943-194613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DEPT OF AGRICULTURE/INSPECTOR

16b. Kind of Business/Industry

WEIGHTS &amp; MEASURES

17. Father's Name (First, Middle, Last)

ALONZO R. HENSEL

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE E. HAGER

19a. Informant's Name/Relationship (Type, Print)

BARBARA J. STITCHER DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

231 CANAL PARK DRIVE A-207 SALISBURY MARYLAND 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SUNSET CEMETERY JULY 13 2000

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME P.A.

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 MIN.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. ANEMIA

Due to (or as a consequence of):

1 hr.

c. CONGESTIVE HEART DISEASE

Due to (or as a consequence of):

d. URINE INFECTION

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dale L. Merritt

29c. License number

D29168

29d. Date signed (Month, Day, Year)

7/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT ALLEN, M.D., 100 POWER ST., SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Diana B. Sparks

State  
RegistrarWalter Russell Hensel  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*Handwritten signature*

NOV 18 1966



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23279

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Louise Harman

2. Date of Death  
Month Day Year  
July 12, 20003. Time of Death  
6:30 a.m.

4a. Facility Name (If not institution, give street and number)

1324 Cove Road

4b. City, Town, or Location of Death

Accident

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

450-05-7462

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Apr. 19, 1915

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Accident

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1324 Cove Road

10f. Zip Code

21520

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

School Cafeteria Manager

16b. Kind of Business/Industry

Garrett Co. Board of Ed.

17. Father's Name (First, Middle, Last)

Fred W. Drees

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Schlottman

19a. Informant's Name/Relationship (Type, Print)

Paul D. Harman | Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

258 Cove Road, Accident, MD 21520

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Zion Church Cemetery, July 15, 2000

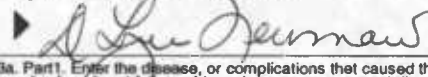
Date

July 15, 2000

20c. Location - City or Town, State

Accident, MD 21520

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Newman Funeral Homes, P.A., 179 Miller Street,  
P.O. Box 275, Grantsville, MD 21536

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Breast Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ovarian Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospitel:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

D54756

29d. Date signed (Month, Day, Year)

July 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R.E. RAPP Jr MD 902 Seton Drive Cumberland MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2026.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 23280

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Helen Kelly</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <b>July</b> Day <b>4</b> , Year <b>2000</b>                                                                                                                        |  | 3. Time of Death<br><b>10:55 p.m.</b>                                                          |                                                                                                                                                                                                  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Cumberland Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                                                                                                                                    |  | 4c. County of Death<br><b>Allegany</b>                                                         |                                                                                                                                                                                                  |
| 5. Social Security Number<br><b>220-07-6404</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 23, 1920</b>                                     |                                                                                                                                                                                                  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |                                                                                                                                                                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. County<br><b>Allegany</b>                                                                                                                                                                                                                                                              |  | 10c. City, Town or Location<br><b>Cumberland</b>                                                                                                                                             |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>314 Prince George Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>21502</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                 |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>office manager</b>                                                                                                                                                          |  | 16b. Kind of Business/Industry<br><b>Z &amp; M Motor Lines</b>                                                                                                                               |  |                                                                                                |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>John Fulton</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret (O'Baker)</b>                                                                                                               |  |                                                                                                |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John F. Kelly son</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>318 Fisher Road; Cumberland MD 21502</b>                                                 |  |                                                                                                |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                          |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery</b>                                                                                                                                                                                        |  | Date<br><b>7/07/</b>                                                                                                                                                                         |  | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>                                   |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br><b>Jerry S. Scarpelli</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home, P.A.<br/>Cumberland, MD 21502</b>                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |                                                                                                |                                                                                                                                                                                                  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Coronary artery disease</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                | Approximate Interval Between Onset and Death<br><b>10 yrs</b>                                                                                                                                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                              |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                              |  |                                                                                                |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                     |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                                                                                                                                                                  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                                                                                                                                                                              |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>D0033280</b>                                                                                                                                                       |  | 29d. Date signed (Month, Day, Year)<br><b>July 6, 2000</b>                                     |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Sunil K. Gupta, M.D., 625 Kent Avenue; Cumberland, MD 21502</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                              |  |                                                                                                |                                                                                                                                                                                                  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23281

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>CHARLOTTE FAYE LEHR</b>                                                                                                                                                                |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>4</b> Year <b>2000</b>                         |                                                                         | 3. Time of Death<br><b>04:19 PM</b>                                                                                                                                                              |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>WMHS Memorial Hospital</b>                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                                   |                                                                         | 4c. County of Death<br><b>Allegany</b>                                                                                                                                                           |  |
| 5. Social Security Number<br><b>217 28 0408</b>                                                                                                                                                                                       |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.                                                                                                                                                                                                                                                          |  | 8. Date of Birth (Month, Day, Year)<br><b>10-21-1932</b>                                    |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                                                                                                                                            |  |
| Usual Residence of Decedent                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| 10a. State<br><b>PA</b>                                                                                                                                                                                                               |  | 10b. County<br><b>Bedford</b>                                                                                                                     |  | 10c. City, Town or Location<br><b>Hyndman</b>                                                                                                                                                                                                                                                             |  |                                                                                             |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |  |
| 10e. Street and Number<br><b>268 Market Street</b>                                                                                                                                                                                    |  |                                                                                                                                                   |  | 10f. Zip Code<br><b>15545</b>                                                                                                                                                                                                                                                                             |  | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                                         |                                                                                                                                                                                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>XX</b>                                                                                                    |  |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                                                                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>                                                                                                    |  |                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse's aide</b>                                                                                                                                                                          |  |                                                                                             | 16b. Kind of Business/Industry<br><b>Health care</b>                    |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Howard Raymond Shaffer, Sr.</b>                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sue Alice Rae Merkel</b>            |                                                                         |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stanley A. Lehr, spouse</b>                                                                                                                                                    |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>268 Market Street, Hyndman, PA 15545</b>                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cooks Mills Cemetery</b>                                                                                                                                                                                                     |  | Date<br><b>7/7/00</b>                                                                       |                                                                         | 20c. Location - City or Town, State<br><b>Hyndman, PA</b>                                                                                                                                        |  |
| 21. Signature of Funeral Service Licensee<br><b>Harvey H. Zeigler</b>                                                                                                                                                                 |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Harvey H. Zeigler Funeral Home<br/>Hyndman, PA 15545</b>                                                                                                                                                                                                           |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>acute arrhythmia</b>   |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                         | Approximate Interval Between Onset and Death<br><b>unk</b>                                                                                                                                       |  |
| Immediate Cause (Final disease or condition resulting in death)<br>e. Due to (or as a consequence of):<br>f. Due to (or as a consequence of):<br>g. Due to (or as a consequence of):<br>h. Due to (or as a consequence of):           |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>lung CA</b>                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                     |  |                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                  |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide          |  | 28a. Date of Injury (Month, Day, Year)                                                                                                            |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                           |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                                                                                                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                |  |                                                                                                                                                   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner                                                                                                                                               |  |                                                                                                                                                   |  | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br><b>Jeffrey Davis M.D.</b>                                                                                                                                                                    |  |                                                                                                                                                   |  | 29c. License number<br><b>D35318</b>                                                                                                                                                                                                                                                                      |  | 29d. Date signed (Month, Day, Year)<br><b>July 7, 2000</b>                                  |                                                                         |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Jeffrey M. Davis Sacred Heart Hospital Seton Drive, Emergency Dept. Cumberland</b>                                                     |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 07 2000</b>                                                                                                                                                                               |  |                                                                                                                                                   |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

ms

State  
Registrar

217-28-0408

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 2058.

Physician  
/Medical  
Examiner

LEHR, CHARLOTTE FAYE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

100 10 3 5000 100 10 3 5000



Amended # 3 mlu  
07/10/00 Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23282

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bertha Mae Lydinger

2. Date of Death

Month Day Year  
July 09 2000

3. Time of Death

2:31 AM

4a. Facility Name (If not institution, give street and number)

Lions Manor Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

215-68-7241

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
May 19, 1909

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

707 Maryland Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Wheeler Day

18. Mother's Name (First, Middle, Maiden Surname)

Molly (Kimble)

19a. Informant's Name/Relationship (Type, Print)

Phyllis Bowen  
daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

60 Summit Place; Frostburg MD 21532

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Scarpelli Funeral Home 7/09/ Cresaptown, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic carcinoma, primary unknown

months

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul Snow MD

29c. License number

D-09157

29d. Date signed (Month, Day, Year)

July 9, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Snow, MD 124 W. 3rd Street, Cumberland MD 21502

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

Beverly B. Smith

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23283

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Lucile Lindner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               | 2. Date of Death<br>Month Day Year<br><b>June 30, 2000</b>                                                                                                                                                                                                                                  |                                                                         | 3. Time of Death<br><b>8:05 A.M.</b>                                                           |  |
|                                                                      | 4a. Facility Name (If not institution, give street and number)<br><b>Cumberland Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                                                                                                                                                                                                                                   |                                                                         | 4c. County of Death<br><b>Allegany</b>                                                         |  |
| Funeral<br>Director                                                  | 5. Social Security Number<br><b>220-32-4563</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.                                                                                                                                             |                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 19, 1913</b>                                                                                                                                                                                                                                |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                                          |  |
|                                                                      | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. County<br><b>Allegany</b>                                                                                                                    |  | 10c. City, Town or Location<br><b>Cumberland</b>                                                                                                                                             |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                                                      | 10e. Street and Number<br><b>135 North Mechanic St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 10f. Zip Code<br><b>21502</b>                                                                                                                                                                |                                                                               | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                 |                                                                         |                                                                                                |  |
|                                                                      | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                               |                                                                                                                                                                                                                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |  |
|                                                                      | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                                                                |                                                                               |                                                                                                                                                                                                                                                                                             | 16b. Kind of Business/Industry<br><b>Homemaker</b>                      |                                                                                                |  |
|                                                                      | 17. Father's Name (First, Middle, Last)<br><b>James L. Donahoe</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  |                                                                                                                                                                                              | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Bertha Agnes Houser</b> |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|                                                                      | 19a. Informant's Name/Relationship (Type, Print)<br><b>B. Ann Bennett (daughter)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11814 Morning Side Drive N.E. Cumberland, Md. 21502</b>                                  |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|                                                                      | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>State Anatomy Board</b>                                                                                         |                                                                               | 20c. Location - City or Town, State<br><b>6/30/00 Baltimore, MD</b>                                                                                                                                                                                                                         |                                                                         |                                                                                                |  |
|                                                                      | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Maryland State Anatomy Board<br/>655 West Baltimore St. Baltimore, Md. 21201</b>                                                                      |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|                                                                      | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Respiratory Arrest</b><br>Due to (or as a consequence of):<br><br>b. <b>Pulmonary Fibrosis</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHF, HTN, Dementia</b><br><br><b>GERD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |                                                                         |                                                                                                |  |
|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                         |                                                                                                |  |
|                                                                      | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                         |                                                                                                |  |
|                                                                      | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                        |                                                                               | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                             |                                                                         | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 28d. Describe how injury occurred                                                                                                                                                            |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|                                                                      | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
| State Registrar                                                      | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | 29c. License number<br><b>D0054004</b>                                                                                                                                                       |                                                                               | 29d. Date signed (Month, Day, Year)<br><b>June 30, 2000</b>                                                                                                                                                                                                                                 |                                                                         |                                                                                                |  |
|                                                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shiv C. Khanna, M.D. 1221E National Highway LaVale, MD 21502</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                                                              |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|                                                                      | 31. Date filed (Month, Day, Year)<br><b>JUL 03 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 32. Registrar's Signature<br>                                                                             |                                                                               |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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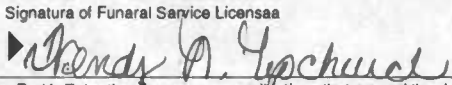
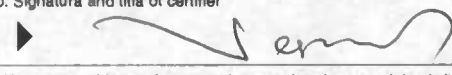
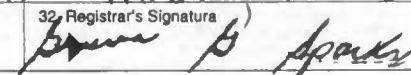
Amended # 166, N.H.S.,  
7/6/00, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23284

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--|-----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><b>DANIEL A. MORRIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                  |                                                                                                                                                   |                                 | 2. Date of Death<br>Month Day Year<br><b>July 04, 2000</b>                                                                                                                                   |                                                                                  |                                                                      |                                   | 3. Time of Death<br><b>03:45 A.M.</b>                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                  |                                                                                                                                                   |                                 | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>                                                                                                                                    |                                                                                  |                                                                      |                                   | 4c. County of Death<br><b>ALLEGANY</b>                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br><b>235-04-9746</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                 | 7. Age (In yrs. last birthday)<br><b>35</b> Yrs.                                                                                                                                             |                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 24, 1964</b>          |                                   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                  |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                  | 10b. County<br><b>ALLEGANY</b>                                                                                                                    |                                 | 10c. City, Town or Location<br><b>CUMBERLAND</b>                                                                                                                                             |                                                                                  |                                                                      |                                   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10e. Street and Number<br><b>601 BEDFORD STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                  |                                                                                                                                                   |                                 | 10f. Zip Code<br><b>21502</b>                                                                                                                                                                |                                                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                       |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                  |                                                                      |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                  |                                                                                                                                                   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b>                                                                 |                                                                                  |                                                                      |                                   | 16b. Kind of Business/Industry<br><b>Automobile</b><br><b>AUTOMOBILE</b>                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 17. Father's Name (First, Middle, Last)<br><b>PHILIP C. MORRIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                  |                                                                                                                                                   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CARLA R. SKIDMORE</b>                                                                                                                |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br><b>CARLA R. MORRIS / MOTHER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                  |                                                                                                                                                   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 319 - WILEY FORD, WV 26767</b>                                                  |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODROW CEMETERY</b>                                                 |                                 | Data<br><b>7/7/00</b>                                                                                                                                                                        |                                                                                  | 20c. Location - City or Town, State<br><b>PAW PAW, WEST VIRGINIA</b> |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                                                                   |                                 | 22. Name and Address of Facility<br><b>UPCHURCH FUNERAL HOME, P.A.</b><br><b>202 GREENE ST., CUMBERLAND, MD 21502</b>                                                                        |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Laryngeal Carcinoma</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>1 1/2 years</b> |                                                                                                                  |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             | Approximate Interval Between Onset and Death                                                                                                                                                     |                                      |  |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension ; History of Head Injury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                  |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                      |  |                                                           |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |                                                                                                                                                                                                  |                                      |  |                                                           |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                  |                                      |  |                                                           |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 27a. Date of Injury (Month, Day Year)                                                                            |                                                                                                                                                   | 27b. Time of Injury<br><b>M</b> |                                                                                                                                                                                              | 27c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                      | 27d. Describe how injury occurred |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
| 27a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 27f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                | 29b. Signature and title of certifier<br>                                                                                                                                                                |                                                                                                                                                                                                  | 29c. License number<br><b>021244</b> |  | 29d. Date signed (Month, Day, Year)<br><b>July 4 2000</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JESUS TAN M.D. FROSTBURG PLAZA, FROSTBURG Md. 21532</b>                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 32. Registrar's Signature<br> |                                                                                                                                                   |                                 |                                                                                                                                                                                              |                                                                                  |                                                                      |                                   |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                                      |  |                                                           |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23285

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Louise Moore

2. Date of Death

Month Day Year  
June 30, 2000

3. Time of Death

10:12 am

4a. Facility Name (If not institution, give street and number)

432 Arch Street

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

219-14-5484

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 16, 1923

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

432 Arch Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edwin F. Knippenburg

18. Mother's Name (First, Middle, Maiden Surname)

Grace L (Wilson)

19a. Informant's Name/Relationship (Type, Print)

Holly McGraw

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12904 Irene Drive; Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Gap Veterans Cem 7/03/

20c. Location - City or Town, State

Flintstone, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic Heart Disease

Approximate Interval Between Onset and Death

Unknown

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Snow

29c. License number

D09157

29d. Date signed (Month, Day, Year)

June 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Paul Snow, Dpty Med Ex 124 W. 3rd Street Cumberland MD 21502

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

Paul Snow

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1000 0 0 0000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23286

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MYRTLE LUCILLE MORELAND

2. Date of Death

July 1, 2000

3. Time of Death

5:40 PM

4a. Facility Name (If not institution, give street and number)

Dennett Road Manor

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

215-14-6016

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

8/31/1920

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Grant

10c. City, Town or Location

Mt. Storm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

HC76, Box 108

10f. Zip Code

26739

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Chauncy Zeuelle Henderson

18. Mother's Name (First, Middle, Maiden Surname)

Ida Mae Evans

19a. Informant's Name/Relationship (Type, Print)

Carl J. Moreland/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

HC76, Box 108, Mt. Storm, WV 26739

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Storm Cemetery

Date

7/4/00

20c. Location - City or Town, State

Mt. Storm, WV

21. Signature of Funeral Service Licensee

B. A. D. D.

22. Name and Address of Facility

32 S. Second St.  
Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. atherosclerotic cardiovascular disease

Approximate Interval Between Onset and Death

1 year

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus type two

parkinson's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Walter K. Naumann MD

29c. License number

D0025759

29d. Date signed (Month, Day, Year)

July 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter K. Naumann MD. PO Box 247 Accident MD 21520

31. Date filed (Month, Day, Year)

JUL - 8 2000

32. Registrar's Signature

B. A. D. D.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23287

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Claude Raymond Maust</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                |                                                                                                                                                   |                                                  | 2. Date of Death<br>Month <b>July</b> Day <b>09</b> Year <b>2000</b>                                                                                                                         |                                                                                                | 3. Time of Death<br><b>10:45 AM</b>                                              |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 4e. Facility Name (If not institution, give street and number)<br><b>Goodwill Mennonite Home</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                   |                                                  | 4b. City, Town, or Location of Death<br><b>Grantsville</b>                                                                                                                                   |                                                                                                | 4c. County of Death<br><b>Garrett</b>                                            |                                                                                                                                                                                                                                                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>175-24-1777</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                                                 | 8. Date of Birth (Month, Day, Year)<br><b>March 14, 1920</b>                     | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>PA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10b. County<br><b>Somerset</b> | 10c. City, Town or Location<br><b>Springs</b>                                                                                                     |                                                  |                                                                                                                                                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>343 Upper Springs Rd., P.O. Box 105</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                   |                                                  | 10f. Zip Code<br><b>15562</b>                                                                                                                                                                |                                                                                                | 10g. Citizen of What Country?<br><b>USA</b>                                      |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                               |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                  |                                | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Janitor</b>                       |                                                  | 16b. Kind of Business/Industry<br><b>Miller Machine Works<br/>Springs School</b>                                                                                                             |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                | 17. Father's Name (First, Middle, Last)<br><b>Norman S. Maust</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                |                                                                                                                                                   |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mayme Kimmel</b>                                                                                                                     |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>Freda L. Maust   Sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                |                                                                                                                                                   |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 105, Springs, PA 15562</b>                                                      |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                        |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lower Springs Cem., July 12, 2000</b>                                |                                                  | Date<br><b>July 12, 2000</b>                                                                                                                                                                 |                                                                                                | 20c. Location - City or Town, State<br><b>Springs, PA 15562</b>                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                                                                                                                   |                                                  | 22. Name and Address of Facility<br><b>Newman Funeral Homes, P.A., 179 Miller St.<br/>P.O. Box 275, Grantsville, MD 21536</b>                                                                |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>STROKE</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>Diabetes Type II</b><br><b>Artherosclerotic Vascular Disease</b> |                                |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  | Approximate Interval Between Onset and Death<br><b>48 hours</b>                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Type II</b><br><b>Artherosclerotic Vascular Disease</b>                                                                                                                                                                                                                                                                                                                |                                |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |
|                                                                                                                                                                                                                                                                                                                                              | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                        |                                |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                              | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                            |                                |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                |                                | 28e. Date of Injury (Month, Day, Year)                                                                                                            |                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                 |                                | 29b. Signature and title of certifier<br>                                                                                                         |                                                  | 29c. License number<br><b>D34079</b>                                                                                                                                                         |                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                      |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                              | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James E. Bertel MD Grantsville MD 21536</b>                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| State<br>Registrar                                                                                                                                                                                                                                                                                                                           | 31. Date filed (Month, Day, Year)<br><b>JUL 13 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                |                                                                                                                                                   |                                                  | 32. Registrar's Signature<br>                                                                                                                                                                |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |



Raymond G. McGehee, III

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I, 27, 28A-F PER MEO G786 8-2-00 WK.

Certificate of Death

Reg. No.

00 23288

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

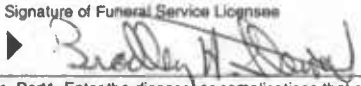
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dr. Raymond Garrett McGehee III</b>                                                                                                                                                                                                                                                                                                                                        |                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>02</b> Year <b>2000</b>                                                                                                                                                                                                                     |                                | 3. Time of Death<br><b>08:50 P.M.</b>                                                                                                                                                        |                                                             |
| 4a. Facility Name (If not institution, give street and number)<br><b>Garrett Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                        |                                                                            | 4b. City, Town, or Location of Death<br><b>Oakland</b>                                                                                                                                                                                                                                   |                                | 4c. County of Death<br><b>Garrett</b>                                                                                                                                                        |                                                             |
| 5. Social Security Number<br><b>224-72-2609</b>                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.                                                                                                                                                                                                                                         | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 23, 1952</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Germany</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                            | Usual Residence of Decedent                                                                                                                                                                                                                                                              |                                |                                                                                                                                                                                              |                                                             |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>Garrett</b>                                              | 10c. City, Town or Location<br><b>Oakland</b>                                                                                                                                                                                                                                            |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                               |                                                             |
| 10e. Street and Number<br><b>140 Joe Whitacre Road</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 10f. Zip Code<br><b>21550</b>                                                                                                                                                                                                                                                            |                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |                                                             |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                        |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                             |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>7</b>                                                                                                                                                     |                                |                                                                                                                                                                                              |                                                             |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dentist</b>                                                                                                                                                                                                                                                                                               |                                                                            | 16b. Kind of Business/Industry<br><b>Family Dentistry</b>                                                                                                                                                                                                                                |                                |                                                                                                                                                                                              |                                                             |
| 17. Father's Name (First, Middle, Last)<br><b>Raymond Garrett McGehee, Jr.</b>                                                                                                                                                                                                                                                                                                                                            |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gay ----- Ellett</b>                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |                                                             |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Karen A. McGehee/Wife</b>                                                                                                                                                                                                                                                                                                                                          |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>140 Joe Whitacre Road, Oakland, Md. 21550</b>                                                                                                                                        |                                |                                                                                                                                                                                              |                                                             |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Taylor-Sines Cemetery</b>                                                                                                                                                                                   |                                | 20c. Location - City or Town, State<br><b>7/8/00 Oakland, Maryland</b>                                                                                                                       |                                                             |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                           |                                                                            | 22. Name and Address of Facility<br><b>Stewart Funeral Home</b><br><b>32 S. Second St. Oakland, Md. 21550</b>                                                                                                                                                                            |                                |                                                                                                                                                                                              |                                                             |
| 23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CARDIAC ARRHYTHMIA FOLLOWING PROBABLE BEE STING</b>                                                                                                                                                     |                                                                            | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |                                                             |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. Due to (or as a consequence of):</b>                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b>                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| <b>c. Due to (or as a consequence of):</b>                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| <b>d. Due to (or as a consequence of):</b>                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |                                                                                                                                                                                              |                                                             |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                            | 28a. Date of Injury (Month, Day, Year)<br><b>7/2/00</b>                                                                                                                                                                                                                                  |                                | 28b. Time of Injury<br><b>7:38</b> P M                                                                                                                                                       |                                                             |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                            | 28d. Describe how injury occurred<br><b>SUBJECT REPORTEDLY STUNG BY BEE</b>                                                                                                                                                                                                              |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>140 JOE WHITE ACRE RD OAKLAND, MD.</b>                                                                    |                                                             |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                              |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                   |                                | 29d. Date signed (Month, Day, Year)<br><b>July 3, 2000</b>                                                                                                                                   |                                                             |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                                                                              |                                                             |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                        |                                |                                                                                                                                                                                              |                                                             |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23289

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br>Ruth Virginia PREASKORN                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        | 2. Date of Death<br>Month Day Year<br>July 12, 2000                                                                                                                                              |                                                                                      |                                                       |                                                                                                                                                                                                          | 3. Time of Death<br>15:02p.m.                             |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        | 4b. City, Town, or Location of Death<br>Cumberland                                                                                                                                               |                                                                                      |                                                       |                                                                                                                                                                                                          | 4c. County of Death<br>Allegany                           |                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br>235-38-9830                                            |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                        | 7. Age (In yrs. last birthday)<br>Yrs. 73                                                                                                                                                        |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>July 17, 1926  |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>West Virginia |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                     | 10b. County<br>Allegany                                                                                                                                                                                                                                                                                 |                                                                                                                                                       | 10c. City, Town or Location<br>Cumberland                                                                              |                                                                                                                                                                                                  |                                                                                      |                                                       | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                         |                                                           |                                                          |  |
| 10e. Street and Number<br>106 Luteman Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 10f. Zip Code<br>21502                                                                                                 |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br>U.S.A.                                              |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                     |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                       | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                           |                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Hygienist |                                                                                                                                                                                                  |                                                                                      | 16b. Kind of Business/Industry<br>Dental              |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>John Oliver Knapp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Meadows                                                                                                                                |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>James D. Preaskorn/Husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>106 Luteman Road Cumberland, MD 21502                                                           |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>East Oak Grove Cemetery                                                     |                                                                                                                        | Date<br>7/15/00                                                                                                                                                                                  |                                                                                      | 20c. Location - City or Town, State<br>Morgantown, WV |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 21. Signature of Funeral Service Licensee<br>S. Mark Saye                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        | 22. Name and Address of Facility<br>Upchurch Funeral Home, P.A.<br>202 Greene St. Cumberland, MD 21502                                                                                           |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Coronary Artery Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           | Approximate Interval Between Onset and Death<br>10 Years |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes Mellitus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                           |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                           |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                           |                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                            |                                                                                     | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                       | 28b. Time of Injury<br>M                                                                                               |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                       | 28d. Describe how injury occurred                                                                                                                                                                        |                                                           |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                     |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 29b. Signature and title of certifier<br>D. Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        | 29c. License number<br>D0033280                                                                                                                                                                  |                                                                                      | 29d. Date signed (Month, Day, Year)<br>July 13, 2000  |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gupta, Sunil K., M.D. Johnson Heights Medical Bldg., Cumberland, Maryland 21502                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                     | 32. Registrar's Signature<br>D. Johnson                                                                                                                                                                                                                                                                 |                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                                                                                          |                                                           |                                                          |  |



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State of Maryland / Department of Health and Mental Hygiene 00 23290

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Russell Kermit Parrish</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. Date of Death<br>Month <b>July</b> Day <b>07</b> Year <b>2000</b>                                                                                                                                                                                                                        |  | 3. Time of Death<br><b>13:50</b>                                                                                                                                                                                                                                        |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Lions Manor Nursing Home</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                       |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                                                                                                                                                                                                                                   |  | 4c. County of Death<br><b>Allegany</b>                                                                                                                                                                                                                                  |  |
| 5. Social Security Number<br><b>236 20 9639</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                            |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                                                                                                                                                                            |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec 23 1919</b>                                                                                                                                                                                                               |  |
| 9. Birthplace (State or Foreign Country)<br><b>W.Va</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 10. Usual Residence of Decedent<br>10a. State <b>WVa</b> 10b. County <b>Mineral</b> 10c. City, Town or Location <b>Elk Garden</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                         |  | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                 |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>                                                                                                              |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                               |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> Collage (1-4 or 5+)                                                                                                                                                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Coal Miner</b>                                                                                                                                          |  |
| 16b. Kind of Business/Industry<br><b>Coal</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph William Parrish</b>                                                                                                                                                                                                                                                                                                              |  | 18. Mother's Name (First, Middle, Maiden Sumame)<br><b>Frances Virginia Clingerman</b>                                                                                                                                                                                                      |  | 19. Informant's Name/Relationship (Type, Print)<br><b>Donald Parrish / Nephew</b>                                                                                                                                                                                       |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Schwinabart Cemetery</b>                                                                                                                                                                                                                                                                                 |  | 20c. Location - City or Town, State<br><b>Elk Garden WV</b>                                                                                                                                                                                                                                 |  | 21. Signature of Funeral Service Licensee<br><b>David A. Burdock</b>                                                                                                                                                                                                    |  |
| 22. Name and Address of Facility<br><b>David A. Burdock FH</b>                                                                                                                                                                                                                                                                                                                                                            |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardiac arrhythmias</b><br>Due to (or as a consequence of):<br><b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                     |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                    |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                       |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |  | 28d. Describe how Injury occurred                                                                                                                                                                                                                                       |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>N.A. Ranjithan</b>                                                                                                                                                                                                                                                                                                                        |  | 29c. License number<br><b>D 19318</b>                                                                                                                                                                                                                                                       |  | 29d. Date signed (Month, Day, Year)<br><b>July 9th, 2000</b>                                                                                                                                                                                                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N.A. Ranjithan, MD, 517 Oldtown Road, Cumberland MD 21502</b>                                                                                                                                                                                                                                                                  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                               |  | 32. Registrar's Signature<br><b>B. [Signature]</b>                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                         |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
**Chronic Renal failure, End stage, Diabetes**  
**COPD, severe, CHF.**

23b. Did tobacco use contribute to the cause of death?  
☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?  
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☐ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death  
☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
**M**

28c. Injury et Work?  
☐ Yes ☒ No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
**N.A. Ranjithan**

29c. License number  
**D 19318**

29d. Date signed (Month, Day, Year)  
**July 9th, 2000**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**N.A. Ranjithan, MD, 517 Oldtown Road, Cumberland MD 21502**

31. Date filed (Month, Day, Year)  
**JUL 11 2000**

32. Registrar's Signature  
**B. [Signature]**

State  
Registrar

Russell Parrish  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

+1 Vet.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23291

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George McClellan Picker

2. Date of Death

July 17 2000

6 PM

3. Time of Death

6 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

217-12-8236

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 3, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Pylesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1703 Harkins Road

10f. Zip Code

21132

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stationary Engineer

16b. Kind of Business/Industry

Furniture Manufacturing

17. Father's Name (First, Middle, Last)

John Milton Picker

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Harrison

19a. Informant's Name/Relationship (Type, Print)

Austin G. Picker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1809 Harkins Road, Pylesville, MD 21132

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Paul's United Methodist Cemetery

Date

7/21/00

20c. Location - City or Town, State

Pylesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.J. Hartenstein Mortuary Inc., 19 S. Main St., Stewartstown, PA 17363

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Cerebrovascular Accident

Approximate Interval Between Onset and Death

1 week

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D34652

29d. Date signed (Month, Day, Year)

July 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Halwell 2 NORTH AVENUE BEL AIR MARYLAND 21014

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

George E. Picker  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Amended # 22, has  
7/6/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23292

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IDA P. RAY

2. Date of Death

Month JULY Day 3, Year 2000

3. Time of Death

8:20 PM

4a. Facility Name (If not institution, give street and number)

CUMBERLAND VILLA NURSING CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

215-20-6300

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year

JUNE 12, 1909

9. Birthplace (State or Foreign)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12007 AMANDA ROAD, S.E.

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

COOK & PASTRY CHEF

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

CLYDE ALVA BALLOU

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE MAY POWELL

19a. Informant's Name/Relationship (Type, Print)

AGNES CASTLEMAN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

87 AUBURN AVENUE, CUMBERLAND, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FAIRVIEW CEMETERY

Date

7/7/00

20c. Location - City or Town, State

ARTEMAS, PENNSYLVANIA

21. Signature of Funeral Service Licensee

Standy R. Upchurch

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE STREET, CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Upper respiratory infection

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Organic brain syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Peter J. Calver

29c. License number

DO 4981

29d. Date signed (Month, Day, Year)

July 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. HALMOS 302 Schley St. Cumberland, Rd 21502

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 06 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Certificate of Death

Reg. No.

00 23293

Physician  
/Medical  
Examiner

Funeral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                               |                               |                                                                                                                                                                                                  |                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN SLIDER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                  | 2. Date of Death<br>Month <b>JULY</b> Day <b>03</b> Year <b>2000</b>                                                                                                                          |                               | 3. Time of Death<br><b>5:30 PM</b>                                                                                                                                                               |                                                       |
| 4a. Facility Name (If not institution, give street and number)<br><b>16107 Misty Lane SW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |                                                  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>                                                                                                                                     |                               | 4c. County of Death<br><b>ALLEGANY</b>                                                                                                                                                           |                                                       |
| 5. Social Security Number<br><b>232 26 2980</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                | If Under 24 Hrs.<br>Hours Min | 8. Date of Birth (Month, Day, Year)<br><b>Mar 24, 1923</b>                                                                                                                                       | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                               |                               |                                                                                                                                                                                                  |                                                       |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. County<br><b>Allegany</b>                                                                                                                                                                                                                                                              |                                                  | 10c. City, Town or Location<br><b>Cumberland</b>                                                                                                                                              |                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                                       |
| 10e. Street and Number<br><b>16107 Misty Lane SW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |                                                  | 10f. Zip Code<br><b>21502</b>                                                                                                                                                                 |                               | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                                       |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>WWII</b>                                                                                                                                |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                               | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                          |                                                       |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired Mechanical Contractor</b>                                             |                               | 16b. Kind of Business/Industry<br><b>Federal's Contracting</b>                                                                                                                                   |                                                       |
| 17. Father's Name (First, Middle, Last)<br><b>Alonzo Slider</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Viola (nmn)</b>                                                                                                                       |                               |                                                                                                                                                                                                  |                                                       |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Colleen L. Slider</b><br><b>Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16107 Misty Lane SW; Cumberland MD 21502</b>                                              |                               |                                                                                                                                                                                                  |                                                       |
| 20a. Method of Disposition (Specify only highest grade completed)<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rocky Gap Veterans Cem</b>                                                                                                                                                                                     |                                                  | Date<br><b>7/06/</b>                                                                                                                                                                          |                               | 20c. Location - City or Town, State<br><b>Flintstone, MD</b>                                                                                                                                     |                                                       |
| 21. Signature of Funeral Service Licensee<br><i>James F. Scarpell</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |                                                  | 22. Name and Address of Facility<br><b>Scarpe III Funeral Home, P.A.</b><br><b>Cumberland, MD 21502</b>                                                                                       |                               |                                                                                                                                                                                                  |                                                       |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                               |                               | Approximate Interval Between Onset and Death<br><br><b>10 min</b><br><br><b>15 yrs</b>                                                                                                           |                                                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal failure on Dialysis, Anemia.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                               |                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                       |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                               |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |                                                       |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                               |                               |                                                                                                                                                                                                  |                                                       |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                       |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |                                                  | 28d. Describe how injury occurred                                                                                                                                                             |                               |                                                                                                                                                                                                  |                                                       |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |                                                  | 28e. Describe how injury occurred                                                                                                                                                             |                               |                                                                                                                                                                                                  |                                                       |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                               |                               |                                                                                                                                                                                                  |                                                       |
| 29b. Signature and title of certifier<br><b>N.A. Ranjithan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                  | 29c. License number<br><b>D 19318</b>                                                                                                                                                         |                               | 29d. Date signed (Month, Day, Year)<br><b>July 4th 2000</b>                                                                                                                                      |                                                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N.A. Ranjithan 517 Oldtown Road Cumberland MD 21502</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                               |                               |                                                                                                                                                                                                  |                                                       |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |                                                  | 32. Registrar's Signature<br><i>Sparks</i>                                                                                                                                                    |                               |                                                                                                                                                                                                  |                                                       |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23294

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUDOLPH EUGENE TEWELL

2. Date of Death

Month  
JULDay  
05Year  
2000

3. Time of Death

12:54 PM

4a. Facility Name (If not Institution, give street and number)

ALLEGANY COUNTY NURSING HOME

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

214-07-1010

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 03 1911

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

PA

10b. County

BEDFORD

10c. City, Town or Location

BEDFORD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1064 BEDFORD VALLEY ROAD

10f. Zip Code

15522

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

TIRE MANUFACTURING

17. Father's Name (First, Middle, Last)

HOWARD S. TEWELL

18. Mother's Name (First, Middle, Maiden Surname)

MELBA SCOTT

19a. Informant's Name/Relationship (Type, Print)

REX D. BENNETT / GRANDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

308 DICKEN ROAD, CLEARVILLE, PA 15535

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CENETERY

Date

JUL 08 2000 CLEARVILLE, PA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DALLA VALLE FUNERAL SERVICE, INC.  
22 WEST MAIN STREET, EVERETT, PA 15537

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF THE ESOPHAGUS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ONE YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-14865

29d. Date signed (Month, Day, Year)

JULY 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBUSTIANO BARRERA, MD., MHMB SUITE 201, CUMBERLAND, MD 21502

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 11 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

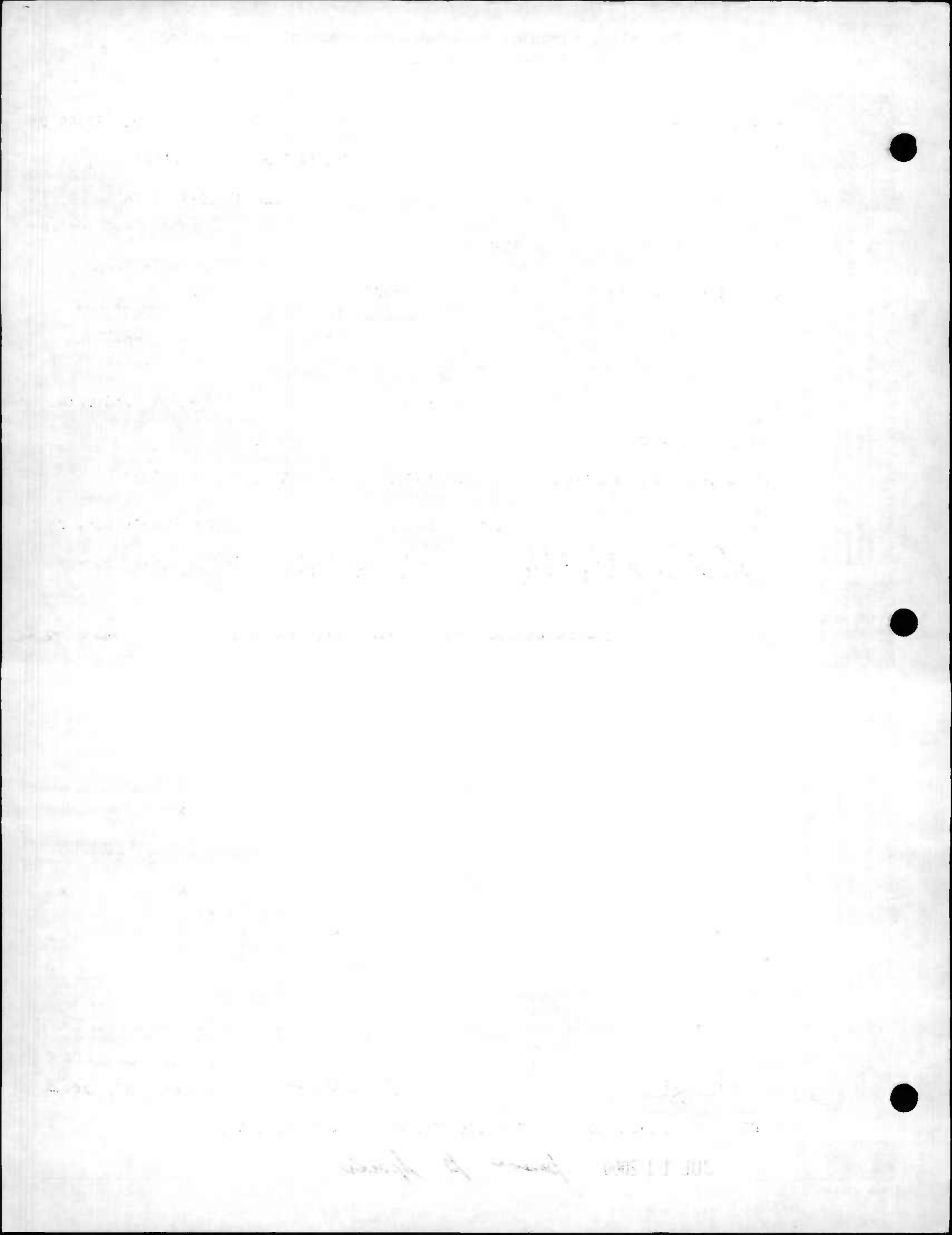
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23295

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>EARL L. WINKLER</b>                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  | 2. Date of Death<br>Month Day Year<br><b>JULY 4, 2000</b>                                                                                                                                     |                                                                                                | 3. Time of Death<br><b>10:15 AM</b>                                                         |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>                                                                                                                                     |                                                                                                | 4c. County of Death<br><b>ALLEGANY</b>                                                      |                                                                                                                                                                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>220-28-9429</b>                                                                                                                                                                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.                                                                                                                                                                                                                                         | If Under 1 Year<br>Months Days                                                                                   | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>October 18, 1933</b>                                 |                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                          | 10b. County<br><b>ALLEGANY</b>                                             | 10c. City, Town or Location<br><b>FROSTBURG</b>                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                             |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>501 GRANDVIEW DRIVE</b>                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                          | 10f. Zip Code<br><b>21532</b>                                                                                    |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                 |                                                                                             |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                    |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                        |                                                                                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                              |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SUPERINTENDENT</b>                                                                                                                                                       |                                                                                                                  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>                                                                                                                                         |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | 17. Father's Name (First, Middle, Last)<br><b>EDWARD THOMAS WINKLER</b>                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIOLA MARY SWAUGER</b>                                                                                                                |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>SUSAN D. WINKLER /WIFE</b>                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>501 GRANDVIEW DRIVE FROSTBURG, MD. 21532</b>                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                             |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FROSTBURG MEMORIAL</b>                                                                                                                                                                                      |                                                                                                                  | Date<br><b>7/6/2000</b>                                                                                                                                                                       |                                                                                                | 20c. Location - City or Town, State<br><b>FROSTBURG, MD.</b>                                |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br><b>DURST FUNERAL HOME P.A.<br/>57 FROST AVENUE FROSTBURG, MD. 21532</b>                                                                                                                                                                              |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Brain Tumour (Glioblastoma)</b><br>Due to (or as a consequence of): |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             | Approximate Interval Between Onset and Death<br><b>8 months</b>                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>c.</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>d.</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD Emphysema. Massive edema due to steroid Therapy and Congestive heart Failure</b>                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                 |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                           |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                   |                                                                                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                             |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                   | 29b. Signature and title of certifier<br><b>SL Sandhu MD</b>               |                                                                                                                                                                                                                                                                                          | 29c. License number<br><b>D 14464</b>                                                                            |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>JULY 4, 2000</b>                                     |                                                                                             |                                                                                                                                                                                                             |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>48 Tarn Terrace, Frostburg MD 21532</b>                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          |                                                                                                                  |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |
| 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                          | 32. Registrar's Signature<br> |                                                                                                                                                                                               |                                                                                                |                                                                                             |                                                                                                                                                                                                             |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12

ms

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23296

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br>MARY LOUISE WILSON                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      | 2. Date of Death<br>Month Day Year<br>July 10, 2000              |                                                                                                                                                                                                          |                                                      | 3. Time of Death<br>12:10 pm                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      | 4b. City, Town, or Location of Death<br>Cumberland               |                                                                                                                                                                                                          |                                                      | 4c. County of Death<br>Allegany                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br>215-20-6407                                            |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br>75 Yrs. |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>FEB 9 1925                |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>MARYLAND |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Usual Residence of Decedent                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 10a. State<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     | 10b. County<br>ALLEGANY                                                                                                                                                                                                                                                                                 |                                                                                | 10c. City, Town or Location<br>CUMBERLAND                                                                                                                                                         |                                           |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |                                                      |                                                          |  |
| 10e. Street and Number<br>719 SHRIVER AVENUE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                | 10f. Zip Code<br>21502                                                                                                                                                                            |                                           | 10g. Citizen of What Country?<br>U.S.A.                                              |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                           |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collega (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOME MAKER                                                                           |                                           |                                                                                      | 16b. Kind of Business/Industry<br>HOME MAKER                     |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>MILTON MILLER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>ROSE VANMETER                   |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>RALPH D. WILSON HUSBAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>719 SHRIVER AVENUE CUMBERLAND MARYLAND 21502                                                     |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GLENDALE CEMETERY                                                                                                       |                                           | 20c. Location - City or Town, State<br>JULY 13 2000 FLINTSTONE, MARYLAND             |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 21. Signature of Funeral Service Licensee<br>Dale L. Merritt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br>MERRITT-ADAMS FUNERAL HOME P.A.<br>404 DECATUR STREET CUMBERLAND MARYLAND                                                                                     |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Lymphoma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      | Approximate Interval Between Onset and Death<br>12 years |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                      |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                      |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                      |                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                     | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                         |                                                                                     | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                          |                                           | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                                                                                                                        |                                                      |                                                          |  |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 29. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 29b. Signature and title of certifier<br>William Lamm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                | 29c. License number<br>D25406                                                                                                                                                                     |                                           | 29d. Date signed (Month, Day, Year)<br>July 10, 2000                                 |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. William Lamm, 47 Virginia Avenue, Cumberland, MD 21502                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     | 32. Registrar's Signature<br>Dennis B Sparks                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                   |                                           |                                                                                      |                                                                  |                                                                                                                                                                                                          |                                                      |                                                          |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



made to meet 1000 & 1000

Amended # 16A mlu

07/12/00 Allegany Co.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23297

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lemuel Richard Walters

2. Date of Death

Month Day Year  
Jul 7, 2000

3. Time of Death

05:15pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

218-24-8602

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sep 5, 1924

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Oldtown

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

18411 Lemuel Drive, SE

10f. Zip Code

21555

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No WW II

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Laborer

16b. Kind of Business/Industry

CSX Trans.

17. Father's Name (First, Middle, Last)

Charles Walters

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle (Buckley)

19a. Informant's Name/Relationship (Type, Print)

Peggy O'Brien

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12407 Bedford Road NE; Cumberland, MD 21502

20a. Place of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oldtown Cemetery

Date

7/10/ Oldtown, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home P.A.

Cumberland, Maryland 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 minutes

b. Pulmonary Embolism

Due to (or as a consequence of):

10 minutes

c. Recurrent Squamous Cell Carcinoma

Due to (or as a consequence of):

1 month

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William D. Lamm M.D.

29c. License number

D25406

29d. Date signed (Month, Day, Year)

Jul 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Lamm M.D. 47 Virginia Avenue Cumberland MD 21502

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

James B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Handwritten signature or initials

JUL 1 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland, Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

000 23298

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Hazim T. Abdulghaffar

2. Date of Death

Month  
JulyDay  
20Year  
2000

3. Time of Death

1:45 P.M.

4a. Facility Name (If not institution, give street and number)

800 Block Ellicott Driveway

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-58-0536

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
01-28-53

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

915 Wildwood Parkway

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

Walter D. Wright

18. Mother's Name (First, Middle, Maiden Surname)

Doris March

19a. Informant's Name/Relationship (Type, Print)

Stacie Ringgold

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1500 Medford Road Baltimore, Maryland 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Mem. Pk. Cem. 07-25-2000 Randallstown, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gabrielle Crow

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C.March FH 1101 E. North Avenue23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

BLUNT FORCE INJURIES

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☒ Homicide28a. Date of Injury  
(Month, Day, Year)

F9-28-00

28b. Time of Injury

FOUND: 1:30

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred:

SUBJECT WAS ASSAULTED

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

FOUND IN WOODED AREA

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

800 BLK. ELLICOTT DR. BALTO MD.

29e. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis Chute

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Dennis B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2026.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23299

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Elizabeth Alvanos

2. Date of Death  
Month Day Year  
JULY 22, 20003. Time of Death  
7:30pm

4a. Facility Name (If not institution, give street and number)

146 Sanford Avenue

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-01-1459

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 7, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

146 Sanford Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Factory work

17. Father's Name (First, Middle, Last)

John Norwood

18. Mother's Name (First, Middle, Maiden Surname)

Mary Haun

19a. Informant's Name/Relationship (Type, Print)

Catherine Mancini/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

146 Sanford Avenue Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

7/24/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC SQUAMOUS CELL CARCINOMA OF TONSIL 2 YEARS  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure. Dysphagia  
Coronary Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ATTENDING PHYSICIAN

29c. License number

D16200

29d. Date signed (Month, Day, Year)

July 24, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NORBERTO M. MACHIRAN, M.D. 720 MAIDEN CHOICE LA. BALTO. MD. 21228

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

B Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23300

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>MIRIAM ASHINSKY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | 2. Date of Death<br>Month Day Year<br><b>JULY 20, 2000</b>                                                                                                                                                                                                                                              |                                | 3. Time of Death<br><b>10:50 PM</b>                                                                                                                                                              |                                                             |
| 4a. Facility Name (If not Institution, give street and number)<br><b>JEWISH CONVALESCENT CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                |                                | 4c. County of Death<br><b>BALTIMORE</b>                                                                                                                                                          |                                                             |
| 5. Social Security Number<br><b>194-09-2623</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.                                                                                                                                                                                                                                                        | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 16, 1912</b> |
| 9. Birthplace (State or Foreign Country)<br><b>LITHUANIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | Usual Residence of Decedent                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                                  |                                                             |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><b>N/A</b>                                                      | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                         |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                               |                                                             |
| 10e. Street and Number<br><b>5720 WHITE AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | 10f. Zip Code<br><b>21206</b>                                                                                                                                                                                                                                                                           |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                   |                                                             |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                             |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)                                                                                                                                                                             |                                |                                                                                                                                                                                                  |                                                             |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | 16b. Kind of Business/Industry<br><b>RETAIL</b>                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                             |
| 17. Father's Name (First, Middle, Last)<br><b>SAMUEL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KELM EVA STALK</b>                                                                                                                                                                                                                              |                                |                                                                                                                                                                                                  |                                                             |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROCHELLE LEWIS / DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5720 WHITE AVENUE - BALTIMORE, MD 21206</b>                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                             |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                   |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LIBERTY PARK SHAAREI ZION</b>                                                                                                                                                                                              |                                | 20c. Location - City or Town, State<br><b>7/23/00 RANDALLSTOWN, MD</b>                                                                                                                           |                                                             |
| 21. Signature of Funeral Service Licensee<br><i>Robert H. Levinson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                                                                                                                                                                             |                                |                                                                                                                                                                                                  |                                                             |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiac Arrhythmia</b><br>Due to (or as a consequence of):<br><b>Ischemic heart disease</b><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Pneumonia</b> |                                                                                | Approximate Interval Between Onset and Death<br><b>Unknown</b><br><b>Unknown</b>                                                                                                                                                                                                                        |                                |                                                                                                                                                                                                  |                                                             |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                |                                |                                                                                                                                                                                                  |                                                             |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                |                                                                                                                                                                                                  |                                                             |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |                                                                                                                                                                                                  |                                                             |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                            |                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |                                                             |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                             |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                     |                                                                                | 29b. Signature and title of certifier<br><i>[Signature]</i> MD                                                                                                                                                                                                                                          |                                | 29c. License number<br><b>027569</b>                                                                                                                                                             |                                                             |
| 29d. Date signed (Month, Day, Year)<br><b>7/21/00</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alan Hettelman 1838 Greene Tree Rd #300</b>                                                                                                                                                                  |                                |                                                                                                                                                                                                  |                                                             |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                             |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23301

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                       |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ILA MAE BRADLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                          |  | 2. Date of Death<br>Month <b>07</b> Day <b>19</b> Year <b>00</b>                                                                                                                                                                                                           |  | 3. Time of Death<br><b>11:35 PM</b>                                                                                                                                                                                                   |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                          |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                                                                                                   |  | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                                                     |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>248-64-8051</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                               |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.                                                                                                                                                                                                                           |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 30, 1938</b>                                                                                                                                                                           |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>SOUTH CAROLINA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                            |  | 10b. County<br><b>N/A</b>                                                                                                                                                                                                                                                  |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>516 NORTH CALHOUN STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10f. Zip Code<br><b>21223</b>                                                                                                                                                                                                                                                            |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                        |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                        |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                              |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                                                               |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12TH GRADE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC WORKER DR. JOHN COSTON</b>                                                                                                                                      |  | 16b. Kind of Business/Industry                                                                                                                                                                                                                                             |  | 17. Father's Name (First, Middle, Last)<br><b>MANNIE</b>                                                                                                                                                                              |  |
|                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALICE SCOTT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>BOBBIE ROBINSON (DAUGHTER)</b>                                                                                                                                                                                                    |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>609 S. WICKHAM ROAD, BALTIMORE, MD. 21229</b>                                                                                                                          |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETERY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20c. Location - City or Town, State<br><b>WOODLAWN, MARYLAND</b>                                                                                                                                                                                                                         |  | 21. Signature of Funeral Service Licensee<br><b>Robert N. Williams</b>                                                                                                                                                                                                     |  | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME<br/>2140 N. FULTON AVE., BALTO. MD. 21217</b>                                                                                                                 |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>MALIGNANT ARYTHMIA</b><br>Due to (or as a consequence of):<br>b. <b>CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>c. <b>HYPERTENSION</b><br>Due to (or as a consequence of):<br>d. <b>RENAL FAILURE</b> |  | 23b. Did tobacco use contribute to the causes of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                        |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                    |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                 |  |
|                                               | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                              |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                        |  | 29b. Signature and title of certifier<br><b>Joseph Shiber CHIEF RESIDENT</b>                                                                                                                                                                                                             |  | 29c. License number<br><b>P10290</b>                                                                                                                                                                                                                                       |  | 29d. Date signed (Month, Day, Year)<br><b>7/19/00</b>                                                                                                                                                                                 |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH SHIBER 22 South Greene St, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 31. Data filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                  |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                            |  | 33. State Registrar                                                                                                                                                                                                                   |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23302

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LUCILLE BROOKS

2. Date of Death

JULY

3

2000

3. Time of Death

7:00 P.M.

4a. Facility Name (If not institution, give street and number)

LEVINDALE NURSING HOME &amp; REHAB.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

226-26-1488A

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JUNE 5, 1918

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5355 DENMORE AVE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

RUFUS MOTLEY

18. Mother's Name (First, Middle, Maiden Surname)

BEATRICE MOTLEY

19a. Informant's Name/Relationship (Type, Print)

SHEILA IRELAND-NEICE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3670 FORESTHILL RD. BALTO. MD. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VET. 7/7/00

Date

20c. Location - City or Town, State

OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee

LEWIS T. GWYNN

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME  
4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Bronchiolitis Obliterans

Approximate Interval Between Onset and Death

months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, Arterial failure  
Respiratory Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D 33943

29d. Date signed (Month, Day, Year)

JULY 21, 00

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

SUSAN M. LEVY, M.D. (LEVINDALE) 2434 W. BELVEDERE AVE. BALTO. MD. 21215

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



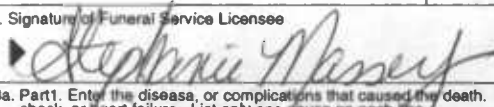
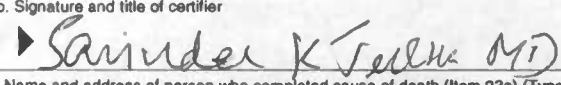
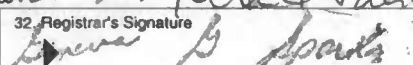


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 23303

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                    |                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br>Henrietta C. Boyer                            |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 20 2000                                              |                                                                                                    | 3. Time of Death<br>6:45 a.m.                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br>Heritage Nursing Center |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Dundalk                                                 |                                                                                                    | 4c. County of Death<br>Baltimore                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br>217-22-2894                                                  |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                             | 7. Age (In yrs. last birthday)<br>Yrs. 73                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br>Feb. 28, 1927                                            |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Usual Residence of Decedent                                                               |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                    |                                                      |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           | 10b. County<br>Baltimore |                                                                                                                                                       | 10c. City, Town or Location<br>Dundalk                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                 | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                      |  |
| 10e. Street and Number<br>1779 Inverness Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 10f. Zip Code<br>21222                                                                                                                                                                                                                                                                                  |                                                                                                 | 10g. Citizen of What Country?<br>United States                                                     |                                                      |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                                                                                                                         |                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 years<br>College (1-4or 5+) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           |                          |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk-Defense Security Service |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 16b. Kind of Business/Industry<br>Federal Government                                            |                                                                                                    |                                                      |  |
| 17. Father's Name (First, Middle, Last)<br>Stanislaus Gregorek                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sophia Rycharski                                                                                                                                                                                                                                   |                                                                                                 |                                                                                                    |                                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Nanci LeBrun (Daughter)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13 German Hill Road Baltimore, Maryland 21222                                                                                                                                                          |                                                                                                 |                                                                                                    |                                                      |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Heart of Jesus                                                       |                                                                                                                                             |                                                                                                                                                                                                   | Date<br>7/22/2000                                                                                                                                                                                                                                                                                       |                                                                                                 | 20c. Location - City or Town, State<br>Dundalk, Maryland                                           |                                                      |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222                                                                                                                                                                                 |                                                                                                 |                                                                                                    |                                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebrovascular Accident<br>Due to (or as a consequence of):<br>b. Seizure Disorder<br>Due to (or as a consequence of):<br>c. Urinary Tract Infection<br>Due to (or as a consequence of):<br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                    |                                                      |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                    |                                                      |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                  |                                                                                                 |                                                                                                    |                                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                 |                                                                                                    |                                                      |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           |                          | 28a. Date of Injury (Month, Day Year)                                                                                                                 |                                                                                                                                             | 28b. Time of Injury<br>M                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                    | 28d. Describe how injury occurred                    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                 |                                                                                                    |                                                      |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                               |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                    |                                                      |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 29c. License number<br>527188                                                                                                                                                                                                                                                                           |                                                                                                 | 29d. Date signed (Month, Day, Year)<br>7/21/00                                                     |                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sander K Teelue 2 Maryland Drive Dundalk 21222                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                    |                                                      |  |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                          |                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                                                                   | 32. Registrar's Signature<br>                                                                                                                                                                                       |                                                                                                 |                                                                                                    |                                                      |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23304

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Lee Boland

2. Date of Death

Month Day Year  
July 23, 2000

3. Time of Death

3:15 a.m.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-05-1109

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 12, 1913

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8833 Walther Blvd. Room 209

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Charles Arthur Smith

18. Mother's Name (First, Middle, Maiden Surname)

Edna Viola Cole

19a. Informant's Name/Relationship (Type, Print)

Frank G. Lidinsky- Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3410 White Ave., Baltimore, MD 21214

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem'l Park

Date

7/26/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

William G. Dau

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.  
5305 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. endstage chronic lung disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Polymyositis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hendee R. Faulkner MD

29c. License number

J25643

29d. Date signed (Month, Day, Year)

07/24/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RR Faulkner MD / 8800 Walther Blvd / Balto MD 21234

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Boland 7/23/2000 3:15 AM

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23305

|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><i>Janet Biden</i>                                                                                                                                                                                                                                                                                                                                                            |                                                                            | 2. Date of Death<br>Month <i>07</i> Day <i>22</i> Year <i>2000</i>                                                                                                                                                                                                                          |                                                         | 3. Time of Death<br><i>10 p.m.</i>                                                                                                                                                               |
|                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br><i>Good Samaritan Hospital</i>                                                                                                                                                                                                                                                                                                                          |                                                                            | 4b. City, Town, or Location of Death<br><i>Baltimore</i>                                                                                                                                                                                                                                    |                                                         | 4c. County of Death<br><i>N/A</i>                                                                                                                                                                |
| Funeral<br>Director                                                                                                                                             | 5. Social Security Number<br><i>219-22-3698</i>                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>72</i> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days                          | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   |
|                                                                                                                                                                 | 8. Date of Birth (Month, Day, Year)<br><i>09-30-1927</i>                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 9. Birthplace (State or Foreign Country)<br><i>Baltimore</i>                                                                                                                                                                                                                                |                                                         |                                                                                                                                                                                                  |
| To Be Completed by Funeral Director                                                                                                                             | 10a. State<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 10b. County<br><i>N/A</i>                                                                                                                                                                                                                                                                   |                                                         | 10c. City, Town or Location<br><i>Baltimore</i>                                                                                                                                                  |
|                                                                                                                                                                 | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 | 10e. Street and Number<br><i>3231 Woodring Avenue</i>                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 10f. Zip Code<br><i>21234</i>                                                                                                                                                                                                                                                               |                                                         | 10g. Citizen of What Country?<br><i>USA</i>                                                                                                                                                      |
|                                                                                                                                                                 | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|                                                                                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (14 or 5+)                                                                                                                                                                                                                                                                                                |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Home Maker</i>                                                                                                                                                              |                                                         | 16b. Kind of Business/Industry<br><i>Own Home</i>                                                                                                                                                |
|                                                                                                                                                                 | 17. Father's Name (First, Middle, Last)<br><i>Edwin Dugan</i>                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Unknown</i>                                                                                                                                                                                                                         |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br><i>John R. Biden-Son</i>                                                                                                                                                                                                                                                                                                                                              |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3231 Woodring Avenue, Baltimore, Md. 21234</i>                                                                                                                                          |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Gardens of Faith Cemetery</i>                                                                                                                                                                                  |                                                         | 20c. Location - City or Town, State<br><i>Baltimore, Md.</i>                                                                                                                                     |
|                                                                                                                                                                 | 21. Signature of Funeral Service Licensee<br><i>Gary R. DiGiovanni</i>                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 22. Name and Address of Facility<br><i>Leonard J. Ruck Funeral Home<br/>5305 Harford Rd. Baltimore, Md 21214</i>                                                                                                                                                                            |                                                         |                                                                                                                                                                                                  |
| Physician<br>/Medical<br>Examiner                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Atherosclerotic heart disease</i>                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         | Approximate Interval Between Onset and Death<br><i>unknown</i>                                                                                                                                   |
|                                                                                                                                                                 | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Myocardial infarction</i><br><i>Anoxic encephalopathy</i>                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         | <i>eleven days</i><br><i>eleven days</i>                                                                                                                                                         |
| To Be Completed by Physician/Medical Examiner                                                                                                                   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |
|                                                                                                                                                                 | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                         | 28b. Time of Injury<br><i>M</i>                                                                                                                                                                  |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                            |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                 | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br><i>Vsevolod Y. Polotsky MD</i>                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                           | 29c. License number<br><i>D0053627</i>                                     |                                                                                                                                                                                                                                                                                             | 29d. Date signed (Month, Day, Year)<br><i>7/22/2000</i> |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Vsevolod Polotsky MD, 143 Wimbledon Lane, Owings Mills, MD 21117</i> |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                  |
| State Registrar                                                                                                                                                 | 31. Date filed (Month, Day, Year)<br><i>JUL 25 2000</i>                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br><i>B. Spots</i>                                                                                                                                                                                                                                                |                                                         |                                                                                                                                                                                                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23306

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Paul Howard Benefield</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>23</b> Year <b>2000</b>                                                                                                                                                                                                                        |                                                                                                                                                     | 3. Time of Death<br><b>5:40 AM</b>                                                                                                                                                           |                                                                                        |
| 4a. Facility Name (If not institution, give street and number)<br><b>Mariner Health of Overlea</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Overlea</b>                                                                                              |                                                                                                                                                                                              | 4c. County of Death<br><b>Baltimore Co.</b>                                            |
| 5. Social Security Number<br><b>217-01-3733</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days                                                                                                                      | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>June 15, 1919</b>                            |
| 9. Birthplace (State or Foreign Country)<br><b>Georgia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10b. County<br><b>Baltimore</b>                                            | 10c. City, Town or Location<br><b>Dundalk</b>                                                                                                                                                                                                                                               |                                                                                                                                                     | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                               |                                                                                        |
| 10e. Street and Number<br><b>6909 Belclare Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | 10f. Zip Code<br><b>21222</b>                                                                                                                                                                                                                                                               |                                                                                                                                                     | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                        |                                                                                        |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>                                                                                                                               |                                                                                                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                        |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+) <b>Supervisor</b>                                                                                                                                     |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 16b. Kind of Business/Industry<br><b>Steel Industry</b>                                                                                                                                                                                                                                     |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 17. Father's Name (First, Middle, Last)<br><b>Lewis O. Benefield</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josephine Holland</b>                                                                       |                                                                                                                                                                                              |                                                                                        |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda Y. Caperna (Daughter)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2701 Parkshire Ct. Fallston, Maryland 21047</b> |                                                                                                                                                                                              |                                                                                        |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>                                                                                                                                                                                          |                                                                                                                                                     | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                            |                                                                                        |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>                                                                                                                                                               |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Dementia Alzheimer's Type</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Due to (or as a consequence of): |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              | Approximate Interval Between Onset and Death<br><b>&gt; 1 wk</b><br><b>&gt; 5 yrs.</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No             |                                                                                                                                                                                              |                                                                                        |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 28a. Date of Injury (Month, Day Year)<br><b>M</b>                                                                                                                                                                                                                                           |                                                                                                                                                     | 28b. Time of Injury<br><b>1</b> Yes <b>2</b> No                                                                                                                                              |                                                                                        |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>D 25391</b>                                                                                                                                                                                                                                                       |                                                                                                                                                     | 29d. Date signed (Month, Day, Year)<br><b>7-24-00</b>                                                                                                                                        |                                                                                        |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. KHAN, 5601- Loch Raven Blvd, Baltimore MD 21239.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                                                                                                     |                                                                                                                                                                                              |                                                                                        |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 23307

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                               |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Sewell Allen Brown, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |                                               | 2. Date of Death<br>Month Day Year<br>July 24 2000                                                                                                                                                       |                                                      | 3. Time of Death<br>0949                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Sinai Hospital of Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                               | 4b. City, Town, or Location of Death<br>Baltimore                                                                                                                                                        |                                                      | 4c. County of Death<br>N/A                                                                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>219-07-2889                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          |                                               | 7. Age (in yrs. last birthday)<br>80 Yrs.                                                                                                                                                                |                                                      | 8. Date of Birth (Month, Day, Year)<br>January 09, 1920                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. County<br>Baltimore Co.                                                                                                                                                                                                                                                                            |                                               | 10c. City, Town or Location<br>Lutherville                                                                                                                                                               |                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br>1813 Blakefield Circle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |                                               | 10f. Zip Code<br>21093                                                                                                                                                                                   |                                                      | 10g. Citizen of What Country?<br>United States of America                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: W.W.II                                                                                                                                            |                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 01                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Chairman of the Board                                                                                                                                                                      |                                               | 16b. Kind of Business/Industry<br>The Belts Corporation                                                                                                                                                  |                                                      |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Sewell Allen Brown, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ada Delcher                                                                                                                                         |                                                      |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Eleanor Brown (nee Bratt) (Wife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1813 Blakefield Circle Lutherville, Maryland 21093                                                      |                                                      |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial Gardens                                                                                                                                                                                               |                                               | Date<br>7/27/2000                                                                                                                                                                                        |                                                      | 20c. Location - City or Town, State<br>Timonium, Maryland                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Jeffrey L. Gair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                                                                                                                                                                                   |                                               |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial Infarction<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                                         |                                               |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Congestive Heart Failure<br>Hypertension                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |                                               | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                      |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                  |                                               |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                               |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                       |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                               | 28b. Time of Injury<br>M                                                                                                                                                                                 |                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         | 28d. Describe how injury occurred             |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                               |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                               |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
| 29b. Signature and title of certifier<br>P. Ogburn MD                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         | 29c. License number<br>P 14279                |                                                                                                                                                                                                          | 29d. Date signed (Month, Day, Year)<br>July 24, 2000 |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sinai Hospital of Baltimore, 2401 W. Belvedere Ave. Baltimore MD 21215                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                               |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         | 32. Registrar's Signature<br>Benita B. Sparks |                                                                                                                                                                                                          |                                                      |                                                                                                    |  |

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State of Maryland / Department of Health and Mental Hygiene 00 23308

Amended Item#1,23A PERPHYG786 8/17/2000 EW  
amend item 18 per fh G786 8/21/00 yg

## Reg. No.

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State of Maryland / Department of Health and Mental Hygiene 00 23309  
Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret E. Blüh</b>                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             | 2. Date of Death<br>Month Day Year<br><b>July 24, 2000</b>                                                                                    |                                                                                                | 3. Time of Death<br><b>1:45 p.m.</b>                                                                                                                                                             |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Roland Park Place</b>                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>                                                                                 |                                                                                                | 4c. County of Death                                                                                                                                                                              |                                                            |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>44-76-6904</b>                                                                                                                                                                                        | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days                                                              | If Under 24 Hrs.<br>Hours Min.                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 9, 1903</b>                                     |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>Germany</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |
| To Be Completed by<br>Funeral Director                                                                                                                                                                                                                                                                                                                                                                                    | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                         | 10b. County                                                                                                                                                                                                                                                                                 | 10c. City, Town or Location<br><b>Baltimore City</b>                                                                                              |                                                                                             |                                                                                                                                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>830 West 40th Street</b>                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 10f. Zip Code<br><b>21211</b>                                                               |                                                                                                                                               | 10g. Citizen of What Country?<br><b>Canada</b>                                                 |                                                                                                                                                                                                  |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                        |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:      |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>8</b>                                                                                                  |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>                       |                                                                                             | 16b. Kind of Business/Industry<br><b>Education</b>                                                                                            |                                                                                                |                                                                                                                                                                                                  |                                                            |
| To Be Completed by<br>Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                          | 17. Father's Name (First, Middle, Last)<br><b>Leo Hornstein</b>                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hermine unknown</b>                                                                   |                                                                                                |                                                                                                                                                                                                  |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Pamela Blüh Van Oosten (daughter)</b>                                                                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8594 Hayshed Lane, Columbia, MD 21045</b> |                                                                                                |                                                                                                                                                                                                  |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                  |                                                                                             | 20c. Location - City or Town, State<br><b>Catonsville, MD</b>                                                                                 |                                                                                                | 20d. Date<br><b>July 26 2000</b>                                                                                                                                                                 |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             | 22. Name and Address of Facility<br><b>Brian T. Chisholm Funeral Services of Duburg Valley, P.A.<br/>200 E. Padonia Rd. Timonium, MD 21093</b>    |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pulmonary Embolus</b> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                | Approximate Interval Between Onset and Death<br><b>3 MIN</b>                                                                                                                                     |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Due to (or as a consequence of):<br><b>Deep Vein Thrombosis</b>                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                | <b>3 W</b>                                                                                                                                                                                       |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Due to (or as a consequence of):                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Due to (or as a consequence of):                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                            |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                                                   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred                                                                                                             |                                                                                                |                                                                                                                                                                                                  |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                   |                                                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                  |                                                                                                |                                                                                                                                                                                                  |                                                            |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |
| 29b. Signature and title of certifier<br><b>[Signature] M.D.</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 29c. License number<br><b>D25662</b>                                                        |                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>7/25/00</b>                                          |                                                                                                                                                                                                  |                                                            |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>3333 N. CALVERT ST BALTO MD 21218</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                           | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                               |                                                                                                                                                                                                                                                                                             | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                   |                                                                                             |                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                            |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23310

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br>Umberto Boer                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br>July 19 2000                                                                                        |                                                                                                                                                                                              | 3. Time of Death<br>4:30 p.m.                                                                                                                                                                    |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br>143 Longview Drive                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 4b. City, Town, or Location of Death<br>Catonsville                                                                                       |                                                                                                                                                                                              | 4c. County of Death<br>Baltimore                                                                                                                                                                 |                                                                  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br>216-28-8506                                                                                                                                                                                                                                                                                                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>77 Yrs.                                                                                                         | If Under 1 Year<br>Months Days                                                                                                            | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth<br>(Month, Day, Year)<br>May 12, 1923                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br>Italy                |
|                                                                                                                                                                                                                                                                                                                                                                                                                | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
| To Be Completed by<br>Funeral Director                                                                                                                                                                                                                                                                                                                                                                         | 10a. State<br>Md                                                                                                                                                                                                                                                                                                                                        | 10b. County<br>Baltimore                                                                                                                                                                                                                                                                    | 10c. City, Town or Location<br>Catonsville                                                                                                        |                                                                                                                                           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                               |                                                                                                                                                                                                  |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 10e. Street and Number<br>143 Longview Drive                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br>21228                                                                                                                            |                                                                                                                                           | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                                                      |                                                                                                                                                                                                  |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Tile Setter                       |                                                                                                                                           | 16b. Kind of Business/Industry<br>Construction                                                                                                                                               |                                                                                                                                                                                                  |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 17. Father's Name (First, Middle, Last)<br>Olive Boer                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Guilia Sacilotto                                                                     |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
| To Be Completed by<br>Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Anita Boer - Wife                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>143 Longview Drive Catonsville, MD 21228 |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                   |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>New Cathedral Cemetery                                                  |                                                                                                                                           | Date<br>7/22/2000                                                                                                                                                                            | 20c. Location - City or Town, State<br>Baltimore, MD                                                                                                                                             |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 22. Name and Address of Facility Witzke Funeral Home<br>1630 Edmondson Avenue Catonsville, Md 21228                                       |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>atherosclerotic heart disease</u><br>Due to (or as a consequence of): |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br>months           |
|                                                                                                                                                                                                                                                                                                                                                                                                                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.                                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                         | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                   | 28b. Time of Injury<br>M                                                                                                                  |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                         | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                   | 28d. Describe how injury occurred                                                                                                         |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 29c. License number<br>D24928                                                                                                             |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br>July 21/00                                                                                                                                                |                                                                  |
| 30. Name and address of person who completed cause of death - (Item 23a) (Type, Print)<br>LEONEL BARAHONA 9910 Frederick Rd Md 21042                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                | 31. Date filed (Month, Day, Year)<br>JUL 24 2000                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                             | 32. Registrar's Signature<br>                                                                                                                     |                                                                                                                                           |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 23311

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>Merle Louise Beckham</b>                                                                                                                                                                         |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br><b>July 24, 2000</b>                                                                                    |                                                              | 3. Time of Death<br><b>3:40 AM</b>                                      |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not Institution, give street and number)<br><b>Rose Manor</b>                                                                                                                                                             |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b>                                                                                  |                                                              | 4c. County of Death<br><b>Howard</b>                                    |                                                                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><b>274-18-9001</b>                                                                                                                                                                                                 |                                                                              | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                                                                                                                                                 |                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>March 21, 1921</b> |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                   |                                                                              | 10b. County<br><b>Howard</b>                                                                                                                          |                                                                                                                               | 10c. City, Town or Location<br><b>Ellicott City</b>                                                                                                                                              |                                                                                                                                               |                                                              |                                                                         | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br><b>3100 North Ridge Road</b>                                                                                                                                                                                          |                                                                              |                                                                                                                                                       |                                                                                                                               | 10f. Zip Code<br><b>21043</b>                                                                                                                                                                    |                                                                                                                                               | 10g. Citizen of What Country?<br><b>USA</b>                  |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                          |                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                               |                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                    |                                                                              |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b> |                                                                                                                                                                                                  |                                                                                                                                               | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br><b>John S. Hill</b>                                                                                                                                                                                  |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Unk.</b>                                                                      |                                                              |                                                                         |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary L. Gladhill/daughter</b>                                                                                                                                                            |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13364 Pipes Lane Sykesville, MD 21784</b> |                                                              |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>                                                |                                                                                                                               | Date<br><b>7/24/00</b>                                                                                                                                                                           |                                                                                                                                               | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensed<br><b>Thomas Gregor</b>                                                                                                                                                                               |                                                                              |                                                                                                                                                       |                                                                                                                               | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>                                                                        |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cerebral Vascular Accident</b>  |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                        |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b>                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>                                                                                                   |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day, Year)                                       |                                                                                                                                                       | 28b. Time of Injury<br>M                                                                                                      |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                          |                                                              | 28d. Describe how Injury occurred                                       |                                                                                                    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| 29b. Signature and title of certifier<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               | 29c. License number<br><b>051860</b>                                                                                                                                                             |                                                                                                                                               |                                                              | 29d. Date signed (Month, Day, Year)<br><b>JULY 24, 2000</b>             |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JONATHAN FISH MD 3460 ELICOTT CEM DR #103 ELICOTT CITY MD 21043</b>                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                               | 32. Registrar's Signature<br><b>Sparks</b>                                                                                                                                                       |                                                                                                                                               |                                                              |                                                                         |                                                                                                    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23312

## Certificate of Death

Reg. No.

Amended item #23a per me g786 8-1-00 wj

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Sarah R. Brenner</b>                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>2000</b>                                                                                                                          |                                                                                                | 3. Time of Death<br><b>3:00 P.M.</b>                                                                                                                                                             |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>3005 Rosekemp Ave.</b>                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                      |                                                                                                | 4c. County of Death                                                                                                                                                                              |                                                                     |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>213-09-5555</b>                                                                                                                                                                                                                                                                                                         | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>03/02/1909</b>                                       |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>               |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                 | 10b. County                                                                                                                                                                                                                                                                                 | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                   |                                      |                                                                                                                                                                                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>3005 Rosekemp Ave.</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 10f. Zip Code<br><b>21214</b>        |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                                                                                                                                                  |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>                    |                                      | 16b. Kind of Business/Industry<br><b>Own Home</b>                                                                                                                                             |                                                                                                |                                                                                                                                                                                                  |                                                                     |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 17. Father's Name (First, Middle, Last)<br><b>Frank Gange</b>                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Lucretia (Unknown)</b>                                                                                                                  |                                                                                                |                                                                                                                                                                                                  |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lucretia Brackett Daughter</b>                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3005 Rosekemp Ave. Baltimore, MD 21214</b>                                                |                                                                                                |                                                                                                                                                                                                  |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                   |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Memorial Gar.</b>                                         |                                      | Date<br><b>07/22</b>                                                                                                                                                                          |                                                                                                | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                                                                                                                      |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             | 22. Name and Address of Facility<br><b>Bradley Ashton Matthews Funeral Home, Inc.<br/>2134 Willow Spring RD Baltimore, MD 21222</b>               |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebrovascular Accident.</b><br>Due to (or as a consequence of): |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br><b>several hrs.</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. <b>Aspiration</b> Congestive heart failure<br>Due to (or as a consequence of):                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | c. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | d.                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br>M             |                                                                                                                                                                                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                                                                                                                                                                  | 28d. Describe how Injury occurred                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                         | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                   |                                      |                                                                                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |                                                                                                                                                                                                  |                                                                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                         | 29b. Signature and title of certifier<br>                                                                                                                                                                |                                                                                                                                                   | 29c. License number<br><b>D22652</b> |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>7/21/00</b>                                          |                                                                                                                                                                                                  |                                                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. S. SRINIVAS 5601 ROCKHAVEN BLVD BALTIMORE MD 21239</b>                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                           | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             | 32. Registrar's Signature<br>                                  |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                     |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23313

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Donald B. Bond

2. Date of Death  
Month Day Year  
July 23, 20003. Time of Death  
6:32 PM

4a. Facility Name (If not institution, give street and number)

Buckingham's Choice Nursing Home

4b. City, Town, or Location of Death

Buckeystown

4c. County of Death

Frederick

5. Social Security Number

579-10-5489

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 20, 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

CA

10b. County

Sonoma

10c. City, Town or Location

Guerneville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

15894 Wright Drive

10f. Zip Code

95446

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Winter Davis Bond

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Susan Nusbaum

19a. Informant's Name/Relationship (Type, Print)

Robert N. Bond Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1020 Green Hill Farm Road, Reisterstown, MD 21136

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bethel United Meth. Cem. 7/27/00

Date

20c. Location - City or Town, State

New Windsor, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eline Funeral Home  
11824 Reisterstown Road  
Reisterstown, MD 2113623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)s. Rectal Carcinoma

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

n/year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic atrial fibrillationAnemiaHypothyroid; Bladder Cancer

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

030496 MD.

29d. Date signed (Month, Day, Year)

7/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis E. Becker MD, 300 W. 9th St, Frederick, MD 21701

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

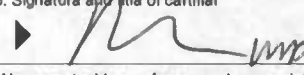

State of Maryland / Department of Health and Mental Hygiene

00 23314

amended item 7 per fh g785 7-25-00

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret ESTELLE BASS</b>              |                                                                                                                                                                                                                                                                                          | 2. Date of Death<br>Month <b>07</b> Day <b>20</b> Year <b>00</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>0954</b>              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br><b>SHOCK TRAUMA</b> |                                                                                                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>         |                                                                                                                                                                                              | 4c. County of Death<br><b>BALTIMORE CITY</b> |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><b>213-10-6998</b>                                       | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.                 | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 19 1916</b>                             |                                                                                                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>MD</b>            |                                                                                                                                                                                              |                                              |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       | 10b. County<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                          |                                                                  | 10c. City, Town or Location<br><b>RANDALLSTOWN</b>                                                                                                                                           |                                              |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 10e. Street and Number<br><b>5448 OLD COURT ROAD #202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       | 10f. Zip Code<br><b>21133</b>                                                                                                                                                                                                                                                            |                                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |                                              |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                        |                                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                              |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                                                                                                                                                            |                                                                  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                                                                                                                            |                                              |
| 17. Father's Name (First, Middle, Last)<br><b>(UNKNOWN)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>(UNKNOWN)</b>                                                                                                                                                                                                                    |                                                                  |                                                                                                                                                                                              |                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>GILBERT BASS / SON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19620 RESH MILL ROAD - HAMPSTEAD, MD 21074</b>                                                                                                                                       |                                                                  |                                                                                                                                                                                              |                                              |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BNAI ISRAEL CEMETERY</b>                                                                                                                                                                                    |                                                                  | 20c. Location - City or Town, State<br><b>7/24/00 BALTIMORE, MD</b>                                                                                                                          |                                              |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                                                                                                                                                              |                                                                  |                                                                                                                                                                                              |                                              |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebral Vascular Accident Secondary to Hypertension</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                                                                                       | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                             |                                                                  |                                                                                                                                                                                              |                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                  |                                                                                                                                                                                              |                                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       | 28a. Date of Injury (Month, Day Year)<br><b>7/21/00</b>                                                                                                                                                                                                                                  |                                                                  | 28b. Time of Injury<br><b>unknown</b>                                                                                                                                                        |                                              |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       | 28d. Describe how injury occurred<br><b>Natural Causes</b>                                                                                                                                                                                                                               |                                                                  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>5448 Old Ct Rd Randallstown MD</b>                                                                        |                                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                        |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 29b. Signature and title of certifier<br><br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       | 29c. License number<br><b>AU4M6435-13309</b>                                                                                                                                                                                                                                             |                                                                  | 29d. Date signed (Month, Day, Year)<br><b>7/22/00</b>                                                                                                                                        |                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ross Bengtson, MD 412 Redwood St. Baltimore, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                                                                                              |                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                         |                                                                  |                                                                                                                                                                                              |                                              |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23315

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Oliver Creed

2. Date of Death

July 19 2000

3. Time of Death

07:12 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Emergency Room Baltimore

4b. City, Town, or Location of Death

4c. County of Death

Funeral  
Director

5. Social Security Number

223-10-9824

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

March 24, 1914

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

502 North Point Road

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Textile

17. Father's Name (First, Middle, Last)

George Washington Creed

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Rector

19a. Informant's Name/Relationship (Type, Print)

Ruth Hagy - Robinson (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

502 North Point Road, Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gdns

Date

July 24, 2000

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Brian T. Chisholm Funeral Services of Dulaney Valley, P.A.  
200 E. Padonia Rd. Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease / History of myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&gt; 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D53124

29d. Date signed (Month, Day, Year)

July 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jimmy Edmond M.D., 4940 Eastern Avenue, Baltimore, Maryland 21224

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WISCONSIN 100 50 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23316

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard T. Clarke, Sr.

2. Date of Death

Month Day Year  
July 21, 2000

3. Time of Death

8:25 AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-30-1561

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
April 18, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

77 Jumpers Circle

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates  
Korean  
Hostilities

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Store/Warehouse Manager

16b. Kind of Business/Industry

Grocery

17. Father's Name (First, Middle, Last)

Paul Clarke

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Wade

19a. Informant's Name/Relationship (Type, Print)

Craig A. Clarke (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5105 Hodges Road, Eldersburg, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

7/24/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Amanda Kelly

22. Name and Address of Facility

Schimunek Funeral Home, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. esophageal cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

July 21, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W.A. Riley GBMC 6701 N. Charles St. Balt. MD 21206

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Benjamin A. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10x1





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23317

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                                                                                 |                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Hazel m Cinotto</b>                                      |                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>2000</b> |                                                                                                                                                                                                                                                                 | 3. Time of Death<br><b>0325</b>                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b> |                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Columbia</b>              |                                                                                                                                                                                                                                                                 | 4c. County of Death<br><b>Howard</b>                       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>312-18-4519</b>                                                         |                                                                                                                                                                                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.                     |                                                                                                                                                                                                                                                                 | 8. Date of Birth (Month, Day, Year)<br><b>June 7, 1923</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>                                              |                                                                                                                                                                                                  | 10a. State<br><b>Md</b>                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10b. County<br><b>Howard</b>                                         |                                                                                                                                                                                                                                                                 | 10c. City, Town or Location<br><b>Ellicott City</b>        |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         | 10e. Street and Number<br><b>4998 Apt. A-2 Dorsey Hall Drive</b>                                                                                                                                 |                                                                            | 10f. Zip Code<br><b>21042</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                  |                                                            |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                 |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                                                                                         |                                                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                    |                                                                            | 16b. Kind of Business/Industry<br><b>Home</b>                                                                                                                                                                                                                                                                                                                                                                                |                                                                      | 17. Father's Name (First, Middle, Last)<br><b>Frank Blackburn</b>                                                                                                                                                                                               |                                                            |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Oakie Good</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dominic Cinotto Jr. Son</b>                                                                                                               |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14222 Day Farm Road Glenelg, Maryland 21737</b>                                                                                                                                                                                                                                                                          |                                                                      | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                           |                                                            |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Roselawn Memorial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | 20c. Location - City or Town, State<br><b>7/28/00 Terre Haute, Indiana</b>                                                                                                                       |                                                                            | 21. Signature of Funeral Service Licensee<br><b>Shanda L Lemmer</b> <b>MO0941</b>                                                                                                                                                                                                                                                                                                                                            |                                                                      | 22. Name and Address of Facility<br><b>Witzke Funeral Home Inc.</b><br><b>5555 Twin Knolls Road Columbia, Maryland 21045</b>                                                                                                                                    |                                                            |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Congestive heart failure</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertension</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>1 week</b> |                                                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                              |                                                            |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumonia</b><br><b>Hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |                                                                      | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                            |  |
| 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                                      | 28d. Describe how injury occurred                                                                                                                                                                                                                               |                                                            |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                            | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                      | 29b. Signature and title of certifier<br><b>Bruce M Conger, MD</b>                                                                                                                                                                                              |                                                            |  |
| 29c. License number<br><b>D37013</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | 29d. Date signed (Month, Day, Year)<br><b>July 20, 2000</b>                                                                                                                                      |                                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bruce M Conger, MD #205, 11055 Little Patuxent Pkwy Columbia, MD</b>                                                                                                                                                                                                                                                              |                                                                      | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                         |                                                            |  |
| 32. Registrar's Signature<br><b>Bruce M Conger</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | 33. Registrar's Signature<br><b>Bruce M Conger</b>                                                                                                                                               |                                                                            | 34. Registrar's Signature<br><b>Bruce M Conger</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                      | 35. Registrar's Signature<br><b>Bruce M Conger</b>                                                                                                                                                                                                              |                                                            |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23318

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|---------------------------------|----------------------------------|----|---------------------------|----------------------------------|----|--|----------------------------------|----|--|----------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><u>John B. Cogan</u>                                |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <u>7</u> Day <u>23</u> Year <u>00</u>                                                                                                                              |                                                                              | 3. Time of Death<br><u>01:36</u>                                                               |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><u>Harbor Hospital Center</u> |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><u>Baltimore</u>                                                                                                                                     |                                                                              | 4c. County of Death<br><u>N/A</u>                                                              |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><u>216-20-6987</u>                                                 |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><u>71</u> Yrs.                                                                                                                                             |                                                                              | 8. Date of Birth (Month, Day, Year)<br><u>Dec. 21, 1928</u>                                    |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10a. State<br><u>MD</u>                                                                         |                                 | 10b. County<br><u>N/A</u>                                                                                                                         |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><u>Baltimore</u>                                                                                                                                              |                                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 10a. Street and Number<br><u>2960 Mallview Rd.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                 |                                                                                                                                                   | 10f. Zip Code<br><u>21230</u>                                                                                                                                                                                                                                                               |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><u>USA</u>                                  |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                        |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                 |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Firefighter</u>                                                                                                                                                             |                                                                                                                                                                                              |                                                                              | 16b. Kind of Business/Industry<br><u>Baltimore City</u>                                        |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 17. Father's Name (First, Middle, Last)<br><u>Paul Wolfe</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                 |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Sarah Wyekoff</u>                                                                                                                                                                                                                   |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Irene Imbragulo, companion</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                 |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2960 Mallview Rd. Baltimore, MD. 21230</u>                                                                                                                                              |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Maryland Veterans Cemetery of Crownsville</u>                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              | 20c. Location - City or Town, State<br><u>Crownsville, MD</u>                |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                 |                                                                                                                                                   | 22. Name and Address of Facility<br><u>Ambrose Funeral Home, Inc.</u><br><u>1328 Sulphur Spring Rd. Arbutus, MD. 21227</u>                                                                                                                                                                  |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><u>Ventricular Fibrillation</u></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><u>myocardial Infarct</u></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table> |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <u>Ventricular Fibrillation</u> | Due to (or as a consequence of): | b. | <u>myocardial Infarct</u> | Due to (or as a consequence of): | c. |  | Due to (or as a consequence of): | d. |  | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                       | a.                                                                                              | <u>Ventricular Fibrillation</u> | Due to (or as a consequence of):                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | b.                                                                                              | <u>myocardial Infarct</u>       | Due to (or as a consequence of):                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | c.                                                                                              |                                 | Due to (or as a consequence of):                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | d.                                                                                              |                                 | Due to (or as a consequence of):                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                 |                                                                                                                                                   | 25. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                 |                                                                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                                                              | 28b. Time of Injury<br><u>M</u>                                              |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                 |                                                                                                                                                   | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                                                              | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                               |                                                                                                 |                                 |                                                                                                                                                   | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                                                                                                                                              | 29c. License number<br><u>D 30 037</u>                                       |                                                                                                | 29d. Date signed (Month, Day, Year)<br><u>7/24/00</u>                                       |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>DANIEL CAMACHO M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 25 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                                 |                                                                                                                                                   | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                                                                                                                                                              |                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                   |    |                                 |                                  |    |                           |                                  |    |  |                                  |    |  |                                  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23319

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irving Isadore Cohen

2. Date of Death

Month Day Year  
July 17 2000

3. Time of Death

2115

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

059-10-3290

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT 20, 1915

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5711 Green Spring Avenue

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Chemist

16b. Kind of Business/Industry

Food Technology

17. Father's Name (First, Middle, Last)

David Cohen

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Lipsitz

19a. Informant's Name/Relationship (Type, Print)

Barbara Azzinaro/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11630 Old Brookville Ct. Reston, VA 20194

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

7/21/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

a. Due to (or as a consequence of):

Sepsis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES000

29d. Date signed (Month, Day, Year)

July 19, 2000

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)

Sean McGarr, MD, 2401 West Belvedere Avenue, Baltimore, MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be secured within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

W J



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23320

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

David Ellis Crook, Sr.

2. Date of Death

Month Day Year  
July 24, 2000

3. Time of Death

9:45 AM

4a. Facility Name (If not institution, give street and number)

4774 Chapel Square

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

5. Social Security Number

217-38-5773

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 20, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4774 Chapel Square

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbing Company

17. Father's Name (First, Middle, Last)

James Crook

18. Mother's Name (First, Middle, Maiden Surname)

Grace Westervelt

19a. Informant's Name/Relationship (Type, Print)

Ruth Ann Crook / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4774 Chapel Square Arbutus, MD 21227

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 07/25/00

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licenses

George E. MacNabb

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pulmonary Embolism  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

5 min

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, Type II

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-44243

29d. Date signed (Month, Day, Year)

July 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. William Cook, IV, M.D. 1120 N. Rolling Road Baltimore, MD 21228

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23321

## Certificate of Death

Reg. No.

|                                                                                                                                                                                |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              |                                                                  |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                                                                                                               |                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br><u>JOE C. CHANDLER</u>                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month <u>07</u> Day <u>19</u> Year <u>00</u> |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                                                                                                               | 3. Time of Death<br><u>9:30 PM</u>              |  |
|                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br><u>SINAI HOSPITAL</u> |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>         |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                                                                                                               | 4c. County of Death<br><u>N/A</u>               |  |
| Funeral<br>Director                                                                                                                                                            | 5. Social Security Number<br><u>R50-38-3402</u>                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><u>73</u> Yrs.                 |                                                                                                                                                                                                                                                                                             | If Under 1 Year<br>Months Days |                                                                                                                                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                  |  |
|                                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><u>01-14-27</u>                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><u>SC</u>                      |                                                                                                                                                                                              | 10a. State<br><u>MD</u>                                          |                                                                                                                                                                                                                                                                                             | 10b. County<br><u>N/A</u>      |                                                                                                                                                                                                                                                                               | 10c. City, Town or Location<br><u>BALTIMORE</u> |  |
| Usual Residence of Decedent                                                                                                                                                    |                                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 10e. Street and Number<br><u>2812 PARKWOOD AVENUE</u>                                                                                                                                        |                                                                  | 10f. Zip Code<br><u>21217</u>                                                                                                                                                                                                                                                               |                                | 10g. Citizen of What Country?<br><u>USA</u>                                                                                                                                                                                                                                   |                                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                      |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u>                                                                                                                                                                                                                     |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6 TH GRADE</u><br>College (1-4 or 5+) <u>N/A</u>                                                                                                                            |                                                 |  |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>SANITATION ENGINEER</u>                                         |                                                                                         | 16b. Kind of Business/Industry<br><u>CITY OF BALTIMORE</u>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 17. Father's Name (First, Middle, Last)<br><u>EDWARD CHANDLER</u>                                                                                                                            |                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>CANDICE BARR</u>                                                                                                                                                                                                                    |                                | 19a. Informant's Name/Relationship (Type, Print)<br><u>MARTHA CHANDLER WIFE</u>                                                                                                                                                                                               |                                                 |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2812 PARKWOOD AVE., BALTO. MD. 21217</u>                                   |                                                                                         | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                  |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>KING MEMORIAL PARK</u>                                                                                          |                                                                  | 20c. Location - City or Town, State<br><u>7-28-00 RANDALLSTOWN, MD</u>                                                                                                                                                                                                                      |                                | 21. Signature of Funeral Service Licensee<br><u>Vaughn C. H.</u>                                                                                                                                                                                                              |                                                 |  |
| 22. Name and Address of Facility<br><u>VAUGHN C. GREENE FUNERAL SERVICE</u><br><u>5151 BALTO. NATL PIKE, BALTO. MD. 21229</u>                                                  |                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <u>METASTATIC LUNG CANCER</u><br>Due to (or as a consequence of):<br>b. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>Due to (or as a consequence of):<br>c. <u>HYPERTENSION</u><br>Due to (or as a consequence of):<br>d. _____ |                                                                            | Approximate Interval Between Onset and Death                                                                                                                                                 |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                         |                                                 |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                                                                                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                 |                                                                            | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            |                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |                                                 |  |
| 28a. Date of Injury (Month, Day, Year)                                                                                                                                         |                                                                                         | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                  |                                                                  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                        |                                                 |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |                                                                                         | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                              |                                                                            | 29b. Signature and title of certifier<br><u>Vijay Reddy</u>                                                                                                                                  |                                                                  | 29c. License number<br><u>D47644</u>                                                                                                                                                                                                                                                        |                                | 29d. Date signed (Month, Day, Year)<br><u>JULY 20, 2000</u>                                                                                                                                                                                                                   |                                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>VIJAY REDDY 3100 TOWANDA AVE., BALTO. MD</u>                                        |                                                                                         | 31. Date filed (Month, Day, Year)<br><u>JUL 25 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 32. Registrar's Signature<br><u>Beverly Sparks</u>                                                                                                                                           |                                                                  |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                                                                                                               |                                                 |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23322

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             |                                                                                                                                                                                                  |                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN JEAN CHITTENDEN</b>                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            | 2. Date of Death<br>Month Day Year<br><b>JULY 21 2000</b>   |                                                                                                                                                                                                  | 3. Time of Death<br><b>11:35am</b>                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not Institution, give street and number)<br><b>MORNINGSIDE AT SATYR HILL</b> |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            | 4b. City, Town, or Location of Death<br><b>PARKVILLE</b>    |                                                                                                                                                                                                  | 4c. County of Death<br><b>BALTIMORE</b>                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>217-22-4217</b>                                                    |                                                                                                                                                                                                                                                                                                            | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                                                                                                                                             |                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br><b>10/16/1911</b>    |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Usual Residence of Decedent                                                                        |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | 10b. County<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 10c. City, Town or Location<br><b>PARKVILLE</b>                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                                 |  |
| 10e. Street and Number<br><b>8800 OLD HARFORD RD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 10f. Zip Code<br><b>21234</b>                                                                                                 |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    |                                                                                                                                                                                                                                                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                            |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                          |                                                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b> |                                                                                                                                                                                              |                                                                                                                                            | 16b. Kind of Business/Industry<br><b>HOMEMAKER</b>          |                                                                                                                                                                                                  |                                                                 |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN WINFIELD DEWEES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HELEN ROOT</b>                                                                     |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LINDA WILSON (NIECE)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2464 FITZKEE LANE YORK, PA. 17402.</b> |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CREMATORY</b>                        |                                                                                                                                                                                              | 20c. Location - City or Town, State<br><b>07/21/2000 BALTO., MD.</b>                                                                       |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 21. Signature of Funeral Service Licensee<br><i>William C. Davis III</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              | 22. Name and Address of Facility<br><b>HENRY W. JENKINS &amp; SONS CO.<br/>4905 YORK RD. BALTO., MD. 21212.</b>                            |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Acute Myocardial Infarction</i><br>Due to (or as a consequence of):<br>b. <i>Arteriosclerotic Cardiovascular Disease 16 yrs</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><i>Instant</i> |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                 |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>At Home</i> |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                                                                               |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                |                                                             | 28d. Describe how injury occurred                                                                                                                                                                |                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                 |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                           |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 29b. Signature and title of certifier<br><i>Walter R. Welzant M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 29c. License number<br><b>D 12039</b>                                                                                         |                                                                                                                                                                                              |                                                                                                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 21, 2000</b> |                                                                                                                                                                                                  |                                                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WALTER R. WELZANT M.D. 7600 OSLER DRIVE TOWSON, MD. 21204.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             |                                                                                                                                                                                                  |                                                                 |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | 32. Registrar's Signature<br><i>Benita B. Sparks</i>                                                                                                                                                                                                                                                       |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                              |                                                                                                                                            |                                                             |                                                                                                                                                                                                  |                                                                 |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23323

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES EDWARD DOWNEY JR.

2. Date of Death

Month Day Year  
JULY 17 2000

3. Time of Death

22:15

4e. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-05-5914

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 12, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1004 NORTH ROSEDALE ST.

10f. Zip Code

21216

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAL ENGINEER

16b. Kind of Business/Industry

ASHBURTON APARTMENTS

17. Father's Name (First, Middle, Last)

JAMES EDWARD DOWNEY SR.

18. Mother's Name (First, Middle, Maiden Surname)

PAULINE SMITH

19a. Informant's Name/Relationship (Type, Print)

MARCIA FLOURNOY (COUSIN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1004 NORTH ROSEDALE ST, BALTO, MD. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT CALVARY CEMETERY

Date

7-22-00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] ERICKSON, MD

29c. License number

RES000

29d. Date signed (Month, Day, Year)

JULY 17, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SINAI HOSPITAL OF BALTIMORE 2401 WEST BELVEDERE AVENUE

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

ORIGINAL

DOWNEY, JAMES E  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                              |  |                                                                                |                                                                                                                                                                                                          |                                                            |  |                                                            |                                                                                                                                                                                                                                                                                                                      |                                                       |                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>FRANCIS X. DONOHUE</b>                                        |  |                                                                                |                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br><b>JULY 16, 2000</b> |  |                                                            |                                                                                                                                                                                                                                                                                                                      | 3. Time of Death<br><b>8:07 P.M.</b>                  |                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not Institution, give street and number)<br><b>SELFORD ROAD at SULPHUR SPRING ROAD</b> |  |                                                                                |                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br><b>ARBUTUS</b>     |  |                                                            |                                                                                                                                                                                                                                                                                                                      | 4c. County of Death<br><b>BALTIMORE</b>               |                               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>218-26-2075</b>                                                              |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>May 23, 1931</b> |                                                                                                                                                                                                                                                                                                                      | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                  |  |                                                                                |                                                                                                                                                                                                          | 10a. State<br><b>MD</b>                                    |  |                                                            |                                                                                                                                                                                                                                                                                                                      | 10b. County<br><b>Baltimore</b>                       |                               |  |
| 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                              |  |                                                                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                            |  |                                                            | 10e. Street and Number<br><b>5615 Chelwynd Road</b>                                                                                                                                                                                                                                                                  |                                                       | 10f. Zip Code<br><b>21227</b> |  |
| 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                              |  |                                                                                | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                   |                                                            |  |                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                |                                                       |                               |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                             |                                                                                                              |  |                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                                  |                                                            |  |                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                |                                                       |                               |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>instructor</b>                                                                                                                                                                                                                                                                                                |                                                                                                              |  |                                                                                | 16b. Kind of Business/Industry<br><b>rehabilitation</b>                                                                                                                                                  |                                                            |  |                                                            | 17. Father's Name (First, Middle, Last)<br><b>Edward P. Donohue</b>                                                                                                                                                                                                                                                  |                                                       |                               |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria P. Koval</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                              |  |                                                                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>O.C.M.E.</b>                                                                                                                                      |                                                            |  |                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>111 Penn Street Baltimore, MD 21201</b>                                                                                                                                                                          |                                                       |                               |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |                                                                                                              |  |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                   |                                                            |  |                                                            | 20c. Location - City or Town, State                                                                                                                                                                                                                                                                                  |                                                       |                               |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph B. Van Sant</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                              |  |                                                                                | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                                                                                               |                                                            |  |                                                            | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Intracranial gunshot wound</b><br>Due to (or as a consequence of):                                   |                                                       |                               |  |
| 23b. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                   |                                                                                                              |  |                                                                                | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                            |  |                                                            | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                            |                                                       |                               |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                                              |  |                                                                                | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                    |                                                            |  |                                                            | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                       |                               |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                              |  |                                                                                | 28a. Date of Injury (Month, Day, Year)<br><b>Found 7/16/00 2005 HX</b>                                                                                                                                   |                                                            |  |                                                            | 28b. Time of Injury<br><b>2005 HX</b>                                                                                                                                                                                                                                                                                |                                                       |                               |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                              |  |                                                                                | 28d. Describe how injury occurred<br><b>Subject shot self</b>                                                                                                                                            |                                                            |  |                                                            | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Self road + self</b>                                                                                                                                                                                                              |                                                       |                               |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                              |  |                                                                                | 29b. Signature and title of certifier<br><b>Thomas M. King</b>                                                                                                                                           |                                                            |  |                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                               |                                                       |                               |  |
| 29d. Data signed (Month, Day, Year)<br><b>JULY 17, 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                              |  |                                                                                | 30. Name and address of person who completed cause of death (Part 23a) (Type, Print)<br><b>THEON ONE Miking 111 Penn Street, Baltimore, Maryland 21201</b>                                               |                                                            |  |                                                            | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                              |                                                       |                               |  |
| 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                              |  |                                                                                | 33. State Registrar<br><b>State Registrar</b>                                                                                                                                                            |                                                            |  |                                                            | 34. DHMH 16 Rev 6/95                                                                                                                                                                                                                                                                                                 |                                                       |                               |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23325

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Joel Donati

2. Date of Death

Month Day Year  
July 21, 2000

3. Time of Death

10:30 PM

4a. Facility Name (If not institution, give street and number)

7912 1/2 Diehlwood Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore Co.

Funeral  
Director

5. Social Security Number

194-16-0600

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 8, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7912 1/2 Diehlwood Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Automotive Industry

17. Father's Name (First, Middle, Last)

Charles Donati

18. Mother's Name (First, Middle, Maiden Surname)

Lena Andrezzi

19a. Informant's Name/Relationship (Type, Print)

Mrs. Leona B. Donati/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7912 1/2 Diehlwood Road Dundalk, Maryland 21222

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Ht. of Jesus Cem.

Date

7/25/2000

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION IMMEDIATE  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS NON INSULIN DEPENDENT

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Sunshine, MD

29c. License number

15140

29d. Date signed (Month, Day, Year)

July 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IAN SUNSHINE, MD 6210 PK. HARBOR, BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23326

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                         |  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Litsa Demetriades</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 2. Date of Death<br>Month Day Year<br><b>July 22, 2000</b>                                                                                                                                                                                                                                              |  | 3. Time of Death<br><b>10:32 PM</b>                                                                                                                     |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Perring Parkway Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 4b. City, Town, or Location of Death<br><b>Parkville</b>                                                                                                                                                                                                                                                |  | 4c. County of Death<br><b>Baltimore County</b>                                                                                                          |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-28-9197</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                                                                                                                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br><b>April 12, 1912</b>                                                                                            |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Greece</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10a. State<br><b>Maryland</b>                                                  |  | 10b. County<br><b>Baltimore Co.</b>                                                                                                                                                                                                                                                                     |  | 10c. City, Town or Location<br><b>Parkville</b>                                                                                                         |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 10e. Street and Number<br><b>2807 Upridge Court C</b>                                                                                                                                                                                                                                                   |  | 10f. Zip Code<br><b>21234</b>                                                                                                                           |  |
|                                               | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                 |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b> |  |
|                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 16b. Kind of Business/Industry<br><b>Clothing</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>George Kouroupis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Theodorou</b>                                                                                                                                                                                                                             |  |                                                                                                                                                         |  |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Sotirios Gianoulos / Son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3639 Double Rock Lane Baltimore, MD 21234</b>                                                                                                                                                       |  |                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greek Orthodox Cemetery</b>                                                                                                                                                                                                |  |                                                                                                                                                         |  |
|                                               | 20c. Date<br><b>7/26/2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 20d. Location - City or Town, State<br><b>Woodlawn, Maryland</b>                                                                                                                                                                                                                                        |  |                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Michael E. Canapp</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21214</b>                                                                                                                                                                                                                                    |  |                                                                                                                                                         |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br><br>a. <b>Arterio Sclerotic Heart Disease</b><br>Due to (or as a consequence of):<br><br>b. <b>CHF</b><br>Due to (or as a consequence of):<br><br>c. <b>NIDDM</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequitally list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                |  | Approximate Interval Between Onset and Death<br><br><b>15 yrs.</b><br><br><b>6 yrs.</b><br><br><b>15 yrs.</b>                                                                                                                                                                                           |  |                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Bronchitis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                |  |                                                                                                                                                         |  |
|                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |  |                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                         |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 28a. Date of Injury (Month, Day, Year)<br><b>July 22, 2000</b>                                                                                                                                                                                                                                          |  |                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                         |  |                                                                                                                                                         |  |
|                                               | 28d. Describe how injury occurred<br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 29b. Signature and title of certifier<br><b>Michael E. Canapp</b>                                                                                                                                                                                                                                       |  |                                                                                                                                                         |  |
|                                               | 29c. License number<br><b>D17728</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 29d. Date signed (Month, Day, Year)<br><b>07/24/00</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ba Yin Oung, M.D. 8022 Belair Rd. Baltimore, MD 21236</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 31. Data filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                         |  |
|                                               | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 33. Registrar's Title<br><b>[Signature]</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                                         |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0066.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23327

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br><u>Virginia J. Deeley</u>                       |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  | 2. Date of Death<br>Month <u>July</u> Day <u>22</u> Year <u>2000</u>                 |                                                                                                    | 3. Time of Death<br><u>8 P.M.</u>                           |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4a. Facility Name (If not institution, give street and number)<br><u>8800 WALTHER BLVD.</u> |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  | 4b. City, Town, or Location of Death<br><u>CARNEY</u>                                |                                                                                                    | 4c. County of Death<br><u>BALTIMORE</u>                     |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br><u>201-20-6923</u>                                             |                                 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |                                                                                                                                    | 7. Age (In yrs. last birthday)<br><u>76</u> Yrs.                                                                                                                                                 |                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><u>June 18, 1924</u>                          |                                                                                                    | 9. Birthplace (State or Foreign Country)<br><u>Illinois</u> |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Usual Residence of Decedent                                                                 |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 10a. State<br><u>MARYLAND</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             | 10b. County<br><u>BALTIMORE</u> |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br><u>CARNEY</u>                                                                                       |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                             |                                                                                                                                                                                                          |  |
| 10e. Street and Number<br><u>8800 WALTHER BLVD.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br><u>21234</u>                                                                                                      |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br><u>U.S.A.</u>                                                                                                   |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                  |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>WHITE</u>                            |                                                             |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12 YRS.</u> College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>SCHOOL TEACHER</u> |                                                                                                                                                                                                  |                                                                                                                                                  | 16b. Kind of Business/Industry<br><u>PENNSYLVANIA PUBLIC SCHOOLS SYSTEM</u>          |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br><u>Walter Landgraf</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Lillian Lunder</u>                                                                       |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Denise Simms</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21030 14 DELLWOOD LT. HUNT VALLEY, MARYLAND</u> |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>JEFFERSON MEMORIAL</u>                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                                                                  | 20c. Location - City or Town, State<br><u>2000 PITTSBURGH, PA.</u>                                                                               |                                                                                      | 20d. Date<br><u>July 26</u>                                                                        |                                                             |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |                                 | 22. Name and Address of Facility<br><u>EVANGELICAL CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234</u>                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. Coronary artery disease</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><u>b. _____</u><br>Due to (or as a consequence of):<br><br><u>c. _____</u><br>Due to (or as a consequence of):<br><br><u>d. _____</u> |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             | Approximate Interval Between Onset and Death<br><u>3 years</u>                                                                                                                                           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Ischemic Cardiomyopathy</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             |                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                    | 28b. Time of Injury<br><u>M</u>                                                                                                                                                                  |                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                    | 28d. Describe how Injury occurred                           |                                                                                                                                                                                                          |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                        |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 29b. Signature and title of certifier<br><u>Edward Kasper MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    | 29c. License number<br><u>D34884</u>                                                                                                                                                             |                                                                                                                                                  |                                                                                      | 29d. Date signed (Month, Day, Year)<br><u>July 24, 2000</u>                                        |                                                             |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>DR. EDWARD K. KASPER, MD, 10755 FALLS ROAD LUTHERVILLE, MARYLAND 21093</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             |                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 25 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             |                                 | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                                                                                                                                                                         |                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                                  |                                                                                      |                                                                                                    |                                                             |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23328

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE

DEMENT

2. Date of Death

July 20 2000

3. Time of Death

12:45pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

212-20-0924

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01-20-1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1□ Yes 2□ No

10e. Street and Number

13200 Old Columbia Pike

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Navar Married 2X Married  
3□ Widowed 4□ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1X Yes 2□ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1□ Yes 2X No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Plummer

16b. Kind of Business/Industry

G Donald, Dement

17. Father's Name (First, Middle, Last)

George Walter Dement

18. Mother's Name (First, Middle, Maiden Surname)

Delma Bryan

19a. Informant's Name/Relationship (Type, Print)

Beverly Houser daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2607 Conway Road Odenton, Maryland 21113

20a. Method of Disposition

1□ Burial 2X Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore Washington Crem.

Data

7-24-00

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home Inc.

7601 Sandy Spring Road Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metabolic encephalopathy

Approximate  
Interval Between  
Onset and Death

3 weeks

Due to (or as a consequence of):

b. Renal insufficiency

3 weeks

Due to (or as a consequence of):

c. Liver failure

3 weeks

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NIDDM

CAD

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4X Unknown

24a. Was an autopsy  
performed?

1□ Yes 2X No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1□ Yes 2□ No

25. Was case referred to medical  
examiner?

1□ Yes 2X No

Hospital:

1X Inpatient 2□ ER/Outpatient 3□ DOA

26. Place of Death (Check only one)

Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending  
2□ Accident investigation  
3□ Suicide 6□ Could not be  
4□ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

RES000

29d. Date signed (Month, Day, Year)

7/20/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Schlosser MD, 600 W. Wolfe Street Baltimore MD

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

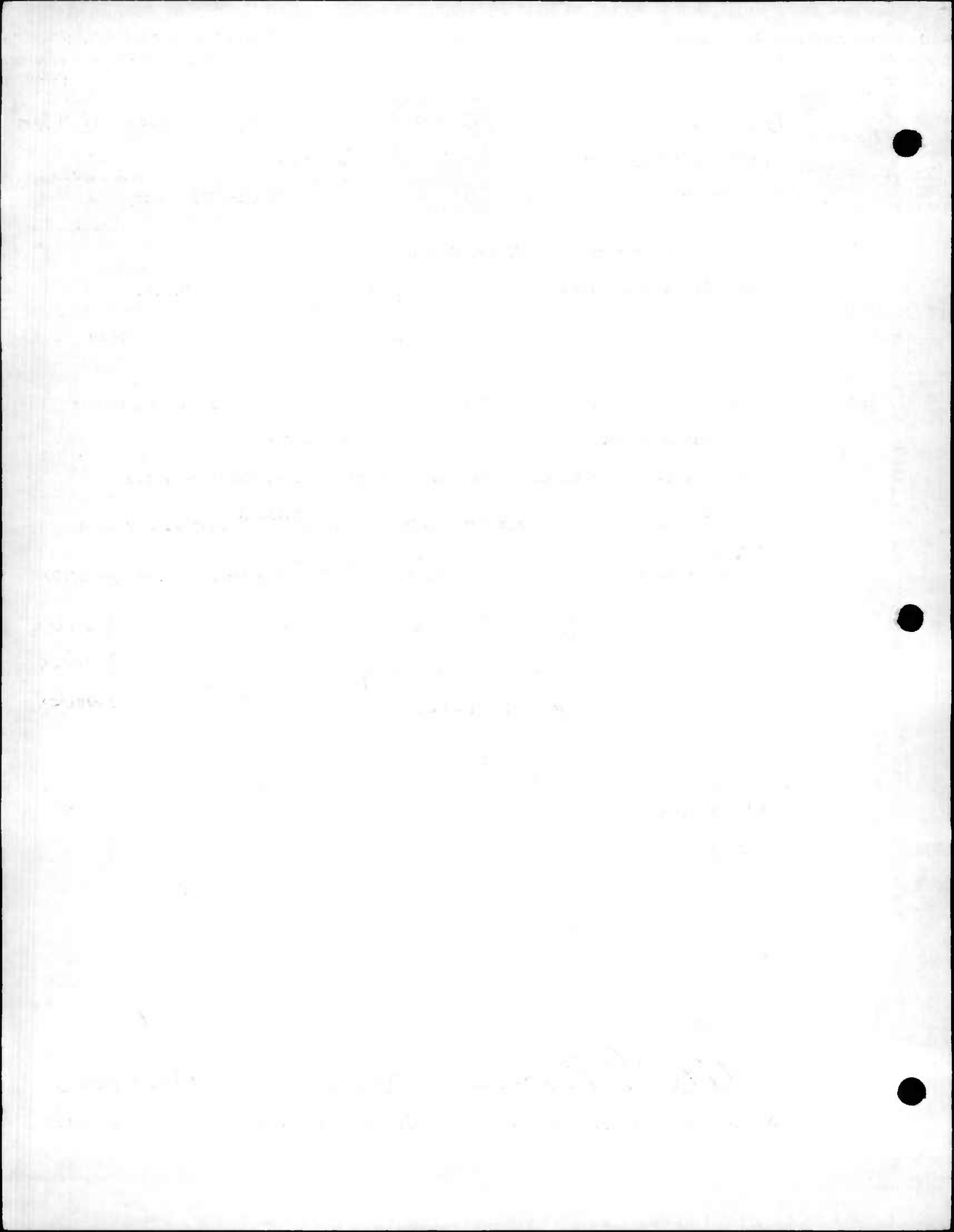
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23329

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Barbara Ann Dimsey-Davis                                                                                                                                                                                                                      |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        | 2. Date of Death<br>Month Day Year<br>July 22 2000                                                                                                                                               |                                                                              | 3. Time of Death<br>3:20 pm                                                                                                                                                                              |                               |
|                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital                                                                                                                                                                                              |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        | 4b. City, Town, or Location of Death<br>Hagerstown                                                                                                                                               |                                                                              | 4c. County of Death<br>Washington                                                                                                                                                                        |                               |
| Funeral<br>Director                                                                                                                                                                                                | 5. Social Security Number<br>219-48-7961                                                                                                                                                                                                                                                  |                                                                                                                                                                                                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>52 Yrs.                                              | If Under 1 Year<br>Months Days                                                                                                                                                                   | If Under 24 Hrs.<br>Hours Min.                                               | 8. Date of Birth (Month, Day, Year)<br>DEC 28, 1947                                                                                                                                                      |                               |
|                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br>District of Columbia                                                                                                                                                                                                                          |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
| To Be Completed by Funeral Director                                                                                                                                                                                | Usual Residence of Decedent                                                                                                                                                                                                                                                               |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
|                                                                                                                                                                                                                    | 10a. State<br>Maryland                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                           | 10b. County<br>Washington                                                                                                                                                                                                                                                                               |                                                                                        | 10c. City, Town or Location<br>Boonsboro                                                                                                                                                         |                                                                              | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                               |
|                                                                                                                                                                                                                    | 10e. Street and Number<br>112 St. Paul Street                                                                                                                                                                                                                                             |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        | 10f. Zip Code<br>21713                                                                                                                                                                           |                                                                              | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |                               |
|                                                                                                                                                                                                                    | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                    |                                                                                                                                                                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                               |
|                                                                                                                                                                                                                    | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12                                                                                                                                                                  |                                                                                                                                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales                                                                                                                                                                                      |                                                                                        | 16b. Kind of Business/Industry<br>Antiques                                                                                                                                                       |                                                                              |                                                                                                                                                                                                          |                               |
|                                                                                                                                                                                                                    | 17. Father's Name (First, Middle, Last)<br>William Owen Dimsey                                                                                                                                                                                                                            |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        | 18. Mother's Name (First, Middle, Maiden Surname)<br>Eileen T. Jones                                                                                                                             |                                                                              |                                                                                                                                                                                                          |                               |
|                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Eileen D. Gibbons/mother                                                                                                                                                                                                              |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>351 Sunbrook Lane Hagerstown, MD 21742                                                          |                                                                              |                                                                                                                                                                                                          |                               |
|                                                                                                                                                                                                                    | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                           |                                                                                                                                                                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.                                                                                                                                                                                                         |                                                                                        | Date<br>7/24/00                                                                                                                                                                                  |                                                                              | 20c. Location - City or Town, State<br>Baltimore, MD                                                                                                                                                     |                               |
|                                                                                                                                                                                                                    | 21. Signature of Funeral Service Licensee<br>Dawn F. McDonald                                                                                                                                                                                                                             |                                                                                                                                                                                                           | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, MD 21228                                                                                                                                                                                       |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
|                                                                                                                                                                                                                    | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                         | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
| Immediate Cause (Final disease or condition resulting in death)<br>e. lung metastasis<br>Due to (or as a consequence of):                                                                                          |                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              | 6 months                                                                                                                                                                                                 |                               |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>f. Breast Cancer<br>Due to (or as a consequence of): |                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              | 27 months                                                                                                                                                                                                |                               |
| g. hepatic metastasis<br>Due to (or as a consequence of):                                                                                                                                                          |                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>hepatic metastasis.                                                                                                                                             |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                               |
|                                                                                                                                                                                                                    | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                 |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                               |
|                                                                                                                                                                                                                    | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                     |                                                                                                                                                                                                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
|                                                                                                                                                                                                                    | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |                                                                                                                                                                                                           | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                        | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                                              | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                               |
|                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                           | 28d. Describe how injury occurred                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                                                                                                                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                          |                               |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |                                                                                                                                                                                                                                                                                           | 29b. Signature and title of certifier<br>Hind Hamdan MD                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          | 29c. License number<br>D46473 |
|                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                           | 29d. Date signed (Month, Day, Year)<br>7/23/00                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Hind Hamdan, MD; 363 S. Cleveland Ave, Hagerstown, MD 21740                                                                |                                                                                                                                                                                                                                                                                           | 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |
| 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                             |                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                          |                               |



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State of Maryland / Department of Health and Mental Hygiene

00 23330

## Certificate of Death

Reg. No.

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                      | 1. Decedent's Name (First, Middle, Last)<br><b>Rebecca Dingle</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>2000</b>                                                                                                                                                                                                                        |                                | 3. Time of Death<br><b>1:05 AM</b>                                                                                                                                                           |
|                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>Augsburg Lutheran Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                                                                                                                    |                                | 4c. County of Death                                                                                                                                                                          |
| Funeral<br>Director                                                    | 5. Social Security Number<br><b>217-22-9224</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                      | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               |
|                                                                        | 8. Date of Birth (Month, Day, Year)<br><b>March 7, 1922</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 | 9. Birthplace (State or Foreign Country)<br><b>SC</b>                                                                                                                                                                                                                                       |                                |                                                                                                                                                                                              |
| To Be Completed by Funeral Director                                    | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                             |                                | 10c. City, Town or Location<br><b>Reisterstown</b>                                                                                                                                           |
|                                                                        | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
|                                                                        | 10e. Street and Number<br><b>20 Fox Run Ct.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 | 10f. Zip Code<br><b>21136</b>                                                                                                                                                                                                                                                               |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |
|                                                                        | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
|                                                                        | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self - Employed</b>                                                                                                                                                         |                                | 16b. Kind of Business/Industry<br><b>Domestic Worker</b>                                                                                                                                     |
|                                                                        | 17. Father's Name (First, Middle, Last)<br><b>Isaac Lemon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Smith</b>                                                                                                                                                                                                                     |                                |                                                                                                                                                                                              |
|                                                                        | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lucille Henson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20 Fox Run Ct., Reisterstown, MD 21136</b>                                                                                                                                              |                                |                                                                                                                                                                                              |
|                                                                        | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All Saints Cemetery</b>                                                                                                                                                                                        |                                | Date<br><b>7/25/00</b>                                                                                                                                                                       |
|                                                                        | 20c. Location - City or Town, State<br><b>Reisterstown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
| 21. Signature of Funeral Service Licensee<br><b>Mark J. Deskiewicz</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 22. Name and Address of Facility<br><b>11824 Reisterstown Rd.<br/>Eline Funeral Home Reisterstown, MD 21136</b> |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
| Physician<br>/Medical<br>Examiner                                      | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>TERMINAL CEREBROVASCULAR THROMBOSIS</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                | Approximate Interval Between Onset and Death<br><b>2 WEEKS</b>                                                                                                                               |
|                                                                        | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
|                                                                        | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                |                                                                                                                                                                                              |
|                                                                        | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |                                                                                                                                                                                              |
|                                                                        | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |
|                                                                        | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                |                                                                                                                                                                                              |
|                                                                        | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                |                                                                                                                                                                                              |
|                                                                        | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                 |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
|                                                                        | 29b. Signature and title of certifier<br><b>Deborah I. Pierce</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 | 29c. License number<br><b>H45931</b>                                                                                                                                                                                                                                                        |                                | 29d. Date signed (Month, Day, Year)<br><b>July 22 2000</b>                                                                                                                                   |
|                                                                        | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Deborah I. Pierce 7220 PARK HEIGHTS AVE BALTIMORE MD 21208</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                              |
|                                                                        | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 | 32. Registrar's Signature<br><b>Bruce B. Sparks</b>                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                              |

Rebecca Dingle  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

AH





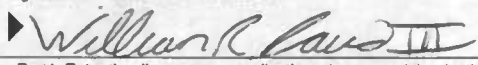


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State of Maryland / Department of Health and Mental Hygiene

00 23331

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1. Decedent's Name (First, Middle, Last)<br><b>MYRTLE B. DUNNOCK</b>                        |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>JULY 19 2000</b> |                                                       |                                                          |                                                                                                                                                                                                          | 3. Time of Death<br><b>2:50AM</b>                           |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4a. Facility Name (If not institution, give street and number)<br><b>GENESIS LONG GREEN</b> |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                                       |                                                          |                                                                                                                                                                                                          | 4c. County of Death<br><b>N/A</b>                           |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5. Social Security Number<br><b>217-10-8970</b>                                             |                                                                                                                                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.          |                                                       | 8. Date of Birth (Month, Day, Year)<br><b>06/09/1914</b> |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Usual Residence of Decedent                                                                 |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             | 10b. County<br><b>N/A</b>                                                                                                                             |                                                                                | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |                                                             |                                              |  |
| 10e. Street and Number<br><b>115 EAST MELROSE AVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                                                                                                                       |                                                                                | 10f. Zip Code<br><b>21212</b>                                                                                                                                                                                                                                                                           |                                                           | 10g. Citizen of What Country?<br><b>USA</b>           |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                        |                                                           |                                                       |                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                  |                                                             |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4YRS</b> College (1-4 or 5+) <b>4YRS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                                                                                                                                       |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BOOKEEPER</b>                                                                                                                                                                           |                                                           |                                                       |                                                          | 16b. Kind of Business/Industry<br><b>BOOKEEPER</b>                                                                                                                                                       |                                                             |                                              |  |
| 17. Father's Name (First, Middle, Last)<br><b>HARRY BROMWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                       |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NETTIE (UNKNOWN)</b>                                                                                                                                                                                                                            |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES BROMWELL (NEPHEW)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                       |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3525 WHEELHOUSE RD. BALTO., MD. 21220.</b>                                                                                                                                                          |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                       |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CREMATORY</b>                                                                                                                                                                                                  |                                                           |                                                       |                                                          | 20c. Location - City or Town, State<br><b>07/20/2000 BALTO, MD.</b>                                                                                                                                      |                                                             |                                              |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                       |                                                                                | 22. Name and Address of Facility<br><b>HENRY W. JENKINS &amp; SONS CO.<br/>4905 YORKRD BALTO., MD. 21212.</b>                                                                                                                                                                                           |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Lymphoma</b><br>Due to (or as a consequence of):<br>f. <b>Anaemia</b><br>Due to (or as a consequence of):<br>g. <b>Protein calorie malnutrition</b><br>Due to (or as a consequence of):<br>h. |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                   |                                                             |                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                                                                                                                       |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |                                                                                                                                                       |                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                           | 28b. Time of Injury<br>M                              |                                                          | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                       |                                                                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                       |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                       |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                               |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             |                                                                                                                                                       |                                                                                | 29c. License number<br><b>D31464</b>                                                                                                                                                                                                                                                                    |                                                           | 29d. Date signed (Month, Day, Year)<br><b>7/19/00</b> |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHOIB HASHMI M.D. 821 N. EUTAW ST. SUITE 308 BALTO. MD. 21201.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                       |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                       |                                                           |                                                       |                                                          |                                                                                                                                                                                                          |                                                             |                                              |  |

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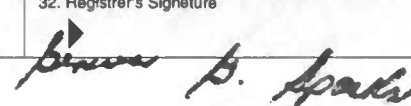
State of Maryland / Department of Health and Mental Hygiene

00 23332

## Certificate of Death

Reg. No.

amended item 15 per fh g785 wj 7-25-00

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><b>Jacob Ezrailson</b>                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>JULY 22 2000</b> |                                                                                             |                                                           |                                                                                                                                                                                                  | 3. Time of Death<br><b>7:30 AM</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban HOSP</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |                                                                                             |                                                           |                                                                                                                                                                                                  | 4c. County of Death<br><b>Montgomery</b>                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br><b>221-01-0981</b>                                        |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.          |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>dec 20 1906</b> |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>Delaware</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Usual Residence of Decedent                                                            |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 10a. State<br><b>Md.</b>                                  |                                                                                             | 10b. County<br><b>Montgomery</b>                          |                                                                                                                                                                                                  | 10c. City, Town or Location<br><b>Rockville</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        | 10e. Street and Number<br><b>6121 Montrose Ave.</b>                                                                                                                                                                                                                                         |                                                                            | 10f. Zip Code<br><b>20852</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        | College (1-4 or 5+)<br><b>XX 4</b>                                                                                                                                                                                                                                                          |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Insurance Agent</b>                                                          |                                                           | 16b. Kind of Business/Industry<br><b>Insurance</b>                                          |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Morris EZRAILSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>                                                                                                                          |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stuart Ezrailson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3009 Cambridge Place N W Washington DC 20007</b>                                         |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Jewish Community Cem.</b>                                                                                                                                                                                      |                                                                            | Date<br><b>7-23-00</b>                                                                                                                                                                       |                                                           | 20c. Location - City or Town, State<br><b>Wilmington, De.</b>                               |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>Sol Levinson &amp; Bros. 8900 Reisterstown Rd,</b>                                                                                                    |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Pneumonia</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           | Approximate interval Between Onset and Death                                                                                                                                                     |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                           | 28d. Describe how injury occurred                                                                                                                                                                |                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        | 29b. Signature and title of certifier<br><b>Patricia L. Tomsko, MD</b>                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 29c. License number<br><b>D51916</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        | 29d. Date signed (Month, Day, Year)<br><b>July 22, 2000</b>                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        | 32. Registrar's Signature<br>                                                                                                                                                                            |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                           |                                                                                                                                                                                                  |                                                             |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

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|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ALICE FOREMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>20</b> Year <b>2000</b>                                                                                                                         |  | 3. Time of Death<br><b>9:20 AM</b>                                                                                                                                                               |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>SINAL HOSPITAL of BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>                                                                                                                                |  | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>228-42-6753</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                   |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 21, 1930</b>                                                                                                                                      |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. County<br><b>N/A</b>                                                                                                                                                                    |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                                  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10e. Street and Number<br><b>1904 RAMBLEWOOD RD. APT. D</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 10f. Zip Code<br><b>21239</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                   |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                            |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LIBRARIAN</b>                                                                                                                                                                                                                                                                                                |  | 16b. Kind of Business/Industry<br><b>BALTO. PUBLIC SCHOOLS</b>                                                                                                                               |  |                                                                                                                                                                                                  |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>ELIJAH WATSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELENA COLLINS</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>JERRY FOREMAN-SON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4132 FALLSTAFF RD. BALTO. MD. 21215</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>                                                                                                                                                                                                                                                                                                                          |  | Date<br><b>7/24/00</b>                                                                                                                                                                       |  | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD.</b>                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Lewis T. Gwynn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22. Name and Address of Facility<br><b>LEWIS T. GWYNN FUNERAL HOME<br/>4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>MYOCARDIAL INFARCT</b><br>Due to (or as a consequence of):<br><b>Coronary Artery Disease</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CONGESTIVE HEART FAILURE AND HYPOTENSION AS A RESULT OF MITRAL REGURGITATION (SEVERE) SECONDARY TO MYOCARDIAL INFARCT OF 1989</b> |  | Approximate Interval Between Onset and Death<br><b>1989</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE AND HYPOTENSION AS A RESULT OF MITRAL REGURGITATION (SEVERE) SECONDARY TO MYOCARDIAL INFARCT OF 1989</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>BARROCAS MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 29c. License number<br><b>RES 000</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>July 20, 2000</b>                                                                                                                                  |  |                                                                                                                                                                                                  |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ALEX M. BARROCAS, MD 2401 W. BELVEDERE AVE., BALTIMORE, MD 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. Registrar's Signature<br><b>Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 23334

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>Ann Forshaw</b>                                    |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. Date of Death<br>Month <b>July</b> Day <b>23</b> Year <b>2000</b>                                                                                                                         |                                 |                                                             |                                                                                                | 3. Time of Death<br><b>5:15am</b>                     |  |
|                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>Eastpoint Nursing Center</b> |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           | 4b. City, Town, or Location of Death<br><b>Eastpoint</b>                                                                                                                                     |                                 |                                                             |                                                                                                | 4c. County of Death<br><b>Baltimore</b>               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>206-18-7939</b>                                                   |                                 | 6. Sex<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.                                                                                                                                             |                                 | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 25 1925</b> |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>PA</b> |  |
|                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                       |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 10a. State<br><b>Md</b>                                                                                                                                                                                                                                                                                                               |                                                                                                   | 10b. County<br><b>Baltimore</b> |                                                                                                                                                   | 10c. City, Town or Location<br><b>Eastpoint</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                       |  |
| 10e. Street and Number<br><b>1046 Old North Point Road</b>                                                                                                                                                                                                                                                                            |                                                                                                   |                                 |                                                                                                                                                   | 10f. Zip Code<br><b>21224</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                 |                                                             | 10g. Citizen of What Country?                                                                  |                                                       |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                        |                                                                                                   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                             |                                                                                                   |                                 |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse Assistant</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                              |                                 |                                                             | 16b. Kind of Business/Industry<br><b>Nursing</b>                                               |                                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown Black</b>                                                                                                                                                                                                                                                                       |                                                                                                   |                                 |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Antionette Unknown</b>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Debbie Sexton / daughter</b>                                                                                                                                                                                                                                                   |                                                                                                   |                                 |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 Emily Lane Fort Meyers Beach FL 33931</b>                                                                                                                                                                                                                                                                          |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                 |                                                                                                   |                                 |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc. 7/25/2000</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             | 20c. Location - City or Town, State<br><b>Baltimore Md.</b>                                    |                                                       |  |
| 21. Signature of Funeral Service Licensee<br><b>B. Terry Connelly</b>                                                                                                                                                                                                                                                                 |                                                                                                   |                                 |                                                                                                                                                   | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex 300 MACE AVE. Baltimore MD. 21221</b>                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute myocardial infarction</b><br>Due to (or as a consequence of):<br><b>Arteriosclerotic Cardiovascular disease</b> |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 23b. Dfd tobacco use contributes to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                          |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                 |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                    |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>                                                                                                                                                                                        |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                     |                                                                                                   |                                 |                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                          |                                                                                                   |                                 |                                                                                                                                                   | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                              | 28b. Time of Injury<br><b>M</b> |                                                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                       |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                 |                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                          |                                                                                                   |                                 |                                                                                                                                                   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                           |                                                                                                   |                                 |                                                                                                                                                   | 29c. License number<br><b>D08358</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                              |                                 |                                                             | 29d. Date signed (Month, Day, Year)<br><b>July 24 2000</b>                                     |                                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GRACIO V. PATRICIO 8903 HARTFORD ROAD BALTIMORE MARYLAND 21234</b>                                                                                                                                                                         |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                               |                                                                                                   |                                 |                                                                                                                                                   | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                              |                                 |                                                             |                                                                                                |                                                       |  |





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State of Maryland / Department of Health and Mental Hygiene

00 23335

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Herbert Nelson Greene SR

2. Date of Death

July 17 00

Day

Year

3. Time of Death

10:05 AM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-12-9186

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MARCH 15, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

4220 COLBORNE ROAD

10f. Zip Code

21229

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 07-12-43  
12-27-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11+ GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STEEL WORKER

16b. Kind of Business/Industry

SPARROWS POINT

17. Father's Name (First, Middle, Last)

FRANK

GREENE

18. Mother's Name (First, Middle, Maiden Surname)

AMANDA

CAUTHORNE

19a. Informant's Name/Relationship (Type, Print)

MARY GREENE (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4220 COLBORNE RD, BALTIMORE, MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CEDAR HILL CEMETERY 7-21-00 GLENBURNIE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Aspiration Pneumonia

Due to (or as a consequence of):

Profound Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 4 days

~ 10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Severe Peripheral Vascular

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Azadi, MD

29c. License number

P13598

29d. Date signed (Month, Day, Year)

July 17, 00

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

St. Agnes Hospital, Baltimore, MD, Mchd: Azadi, MD

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

4x1

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23336

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS EDWARD GEIMAN</b>                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           | 2. Date of Death<br>Month <b>JULY</b> Day <b>23</b> Year <b>2000</b>                                                                                                                         |                                                                                  | 3. Time of Death<br><b>6:30 AM</b>                                      |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           | 4b. City, Town, or Location of Death<br><b>Towson</b>                                                                                                                                        |                                                                                  | 4c. County of Death<br><b>Baltimore</b>                                 |                                                                                                                                                                                                  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>215-03-6820</b>                                                                                                                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days                                                                                                                            | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>Sep. 24, 1916</b>                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           | 10a. State<br><b>Maryland</b>                                                                                                                                                                |                                                                                  | 10b. County<br><b>Baltimore</b>                                         |                                                                                                                                                                                                  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                               |                                                                                  |                                                                         |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>8820 Walther Blvd.</b>                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           | 10f. Zip Code<br><b>21234</b>                                                                                                                                                                |                                                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>College</b>                         |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mailman</b>                       |                                                                                                                                                           | 16b. Kind of Business/Industry<br><b>Post Office</b>                                                                                                                                         |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Geiman</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ivy Bell Morningstar</b>                                                                          |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald J. Geiman (son)</b>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2809 Cold Stream Way, Apt. C, Baltimore, MD 21234</b> |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakeview Memorial Park</b>                                                                                                                                                                                     |                                                                                                                                                   | Date<br><b>7/26/00</b>                                                                                                                                    |                                                                                                                                                                                              | 20c. Location - City or Town, State<br><b>Sykesville, Maryland</b>               |                                                                         |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br><b>Bruce C. Williams</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 22. Name and Address of Facility<br><b>Schimunek Funeral Home, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</b>                                          |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>                                                                                                                                                                    |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         | Approximate Interval Between Onset and Death                                                                                                                                                     |
| a. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| b. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| c. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>TYPE II DIABETES MELLITUS</b><br><b>CHOLECYSTITIS</b>                                                                                                                                                                                                                                      |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                                                                                                           |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         |                                                                                                                                                                                                  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                              |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 29c. License number<br><b>D 37254</b>                                                                                                                     |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>7-24-00</b>                            |                                                                         |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>BOON P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>                                                                                                                                                                                                                                                                   |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                           |                                                                                                                                                                                              |                                                                                  |                                                                         |                                                                                                                                                                                                  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23337

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARION M. GARRISON

2. Date of Death

JULY 24 2000

3. Time of Death

9:36 A. M.

4a. Facility Name (If not institution, give street and number)

St Agnes Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

213-34-3411

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

08-07-36

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1236 Seminole Ave

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technician

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Harold Towns

18. Mother's Name (First, Middle, Maiden Surname)

Lynette Doles

19a. Informant's Name/Relationship (Type, Print)

Jeannine Knight Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1322 Vida Drive Baltimore, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

07-28-00 Woodlawn, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Wylie Funeral Home PA  
638 N. Gilman Street Baltimore, MD 21217

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension  
Due to (or as a consequence of):

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

[Signature] - MD

29c. License number

BG5548994

29d. Date signed (Month, Day, Year)

July 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Greenwald M.D. 900 Calver Avenue Baltimore, MD 21229

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

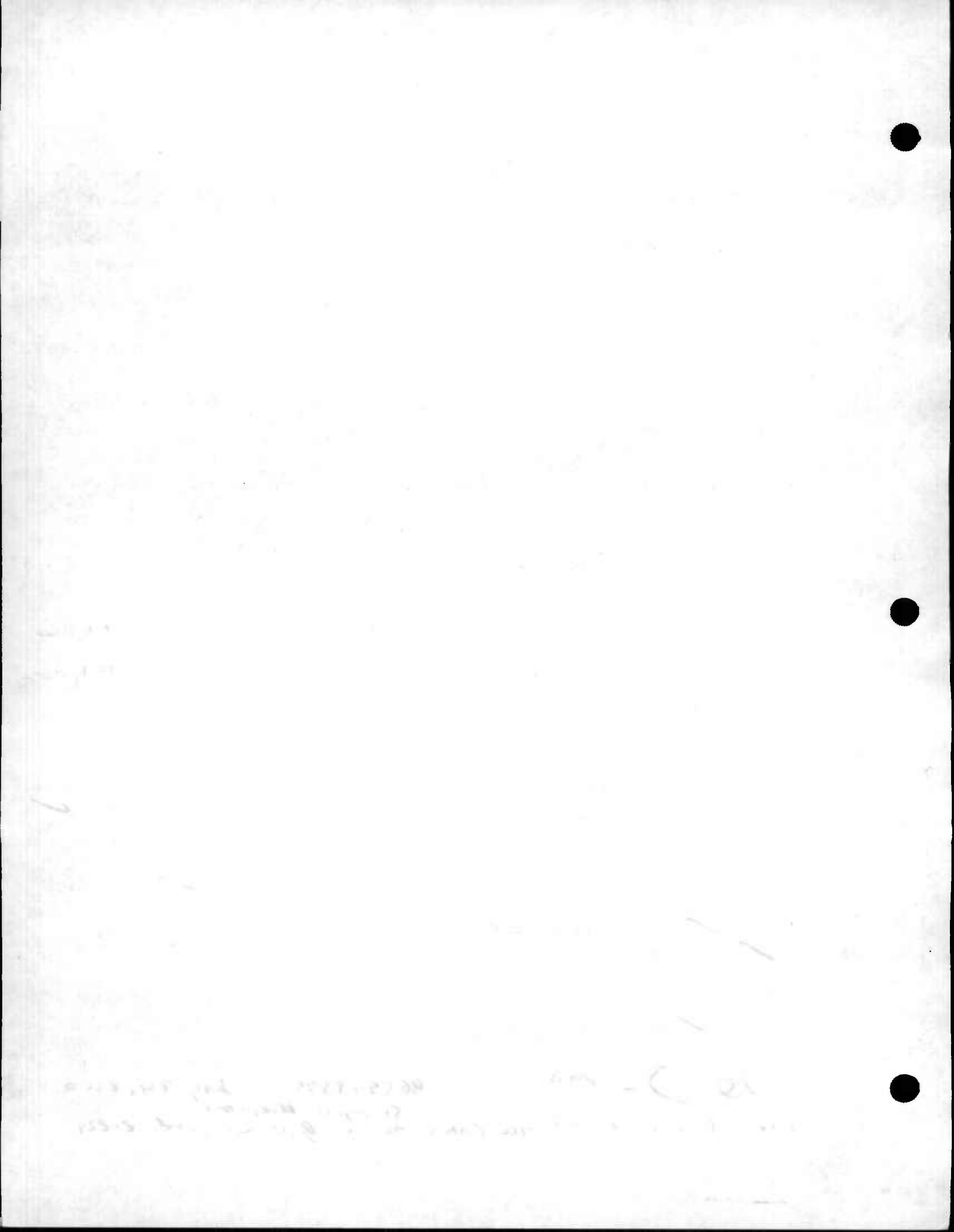
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-2025.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23338

amended item 15 per fh g785 wj

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><i>Kathryn Griffiths</i>                           |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <i>July</i> Day <i>18</i> Year <i>2000</i> |                                                                                                                                                                                              | 3. Time of Death<br><i>20:20</i> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><i>Johns Hopkins Bayview</i> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><i>Baltimore</i>             |                                                                                                                                                                                              | 4c. County of Death              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><i>202-10-0046</i>                                                | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | Age (In yrs. last birthday)<br><i>80</i> Yrs.                        | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs<br>Hours Min.    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. Date of Birth (Month, Day, Year)<br><i>10/25/1919</i>                                       |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><i>PA</i>                |                                                                                                                                                                                              |                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                  |
| 10a. State<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                | 10b. County<br><i>Baltimore</i>                                                                                                                                                                                                                                                             |                                                                      | 10c. City, Town or Location<br><i>Dundalk</i>                                                                                                                                                |                                  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                  |
| 10e. Street and Number<br><i>8211 Bullneck Road</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                | 10f. Zip Code<br><i>21222</i>                                                                                                                                                                                                                                                               |                                                                      | 10g. Citizen of What Country?<br><i>USA</i>                                                                                                                                                  |                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>12</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Substitute Teacher</i>                                                                                                                                                      |                                                                      | 16b. Kind of Business/Industry<br><i>St. Rita's School</i>                                                                                                                                   |                                  |
| 17. Father's Name (First, Middle, Last)<br><i>James Bradley</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Gardy</i>                                                                                                                                                                                                                      |                                                                      |                                                                                                                                                                                              |                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Robert C. Griffiths, Sr. Husband</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8211 Bullneck RD Baltimore, MD 21222</i>                                                                                                                                                |                                                                      |                                                                                                                                                                                              |                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Oaklawn Cemetery</i>                                                                                                                                                                                           |                                                                      | 20c. Location - City or Town, State<br><i>Baltimore, MD</i>                                                                                                                                  |                                  |
| 21. Signature of Funeral Service Licensee<br><i>Bernard Walpole</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                | 22. Name and Address of Facility<br><i>Bradley Ashton Matthews Funeral Home, Inc.<br/>2134 Willow Spring RD Baltimore, MD 21222</i>                                                                                                                                                         |                                                                      |                                                                                                                                                                                              |                                  |
| 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Pulmonary Hemorrhage</i><br>Due to (or as a consequence of):<br><i>b. Probable Lupus</i><br>Due to (or as a consequence of):<br><i>c.</i><br>Due to (or as a consequence of):<br><i>d.</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      | Approximate Interval Between Onset and Death<br><i>1 WEEK</i><br><i>5 YEARS</i>                                                                                                              |                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pulmonary Fibrosis</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                                      |                                                                                                                                                                                              |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                      |                                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                      |                                                                                                                                                                                              |                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                      | 28b. Time of Injury<br>M                                                                                                                                                                     |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |                                                                      | 28d. Describe how injury occurred                                                                                                                                                            |                                  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                      |                                                                                                                                                                                              |                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                          |                                                                                                | 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                 |                                                                      | 29c. License number<br><i>20309</i>                                                                                                                                                          |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                | 29d. Date signed (Month, Day, Year)<br><i>July 18, 2000</i>                                                                                                                                                                                                                                 |                                                                      |                                                                                                                                                                                              |                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Audrey Liu M.D. 4440 KASTLE AVENUE, BALTIMORE, MARYLAND 21224</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 25 2000</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 23339

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia M. Hodges

2. Date of Death

July 22, 2000

3. Time of Death

12:05 PM

4a. Facility Name (If not institution, give street and number)

Hospice Of Baltimore Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-36-4249

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 27, 2000

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

107 Kenilworth Park Drive Apt. 2C

10f. Zip Code

21204

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Steve Mimarou

18. Mother's Name (First, Middle, Maiden Surname)

Maria Vasiliou

19a. Informant's Name/Relationship (Type, Print)

Mr. Peter S. Hodges/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 Kenilworth Park Drive Apt. 2C Towson, MD 21204

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Demetrios Church Cem. 07/25/00 Cub Hill, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

Stephen D. Coster  
M01122

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Org stage Myelodysplasia*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Thrombocytopenia*  
Due to (or as a consequence of):c. *Congestive Heart Failure*  
Due to (or as a consequence of):d. *Small Bowel Obstruction*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypothyroidism*  
*Cholelithiasis*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) *Nursing*

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

00046649

29d. Date signed (Month, Day, Year)

7/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Esmeralda del ROSARIO

6701 N. Chant 88 St 701  
Belted MD 21204

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Beverly P. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



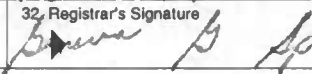


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State of Maryland / Department of Health and Mental Hygiene 00 23340

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                           |                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Amina J. Horlacher                                    |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                        | 2. Date of Death<br>Month Day Year<br>July 21, 2000 |                                                                                                                                                           | 3. Time of Death<br>5:16 AM                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Franklin Square Hospital Center |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                        | 4b. City, Town, or Location of Death<br>Rosedale    |                                                                                                                                                           | 4c. County of Death<br>Baltimore                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>218-14-2765                                                          |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                        | 7. Age (In yrs. last birthday)<br>77 Yrs.           |                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br>January 26, 1923 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br>Baltimore, MD                                         |                                                                                                                                                                                                                                                                                                         | 10a. State<br>MD                                                               |                                                                                                                                                                                                                                                                                                                                                                                        | 10b. County<br>--                                   |                                                                                                                                                           | 10c. City, Town or Location<br>Baltimore                |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                 |                                                                                                   | 10e. Street and Number<br>5930 Glen Oak Avenue                                                                                                                                                                                                                                                          |                                                                                | 10f. Zip Code<br>21214                                                                                                                                                                                                                                                                                                                                                                 |                                                     | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                   |                                                         |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                           |                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                       |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                          |                                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 yrs.                                                                                                                                                                                                                                                                                                                        |                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerical                                                                                                                                                                                   |                                                                                | 16b. Kind of Business/Industry<br>U. S. Government                                                                                                                                                                                                                                                                                                                                     |                                                     |                                                                                                                                                           |                                                         |  |
| 17. Father's Name (First, Middle, Last)<br>Abe Joseph                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Alma Fox                                                                                                                                                                                                                                           |                                                                                | 19a. Informant's Name/Relationship (Type, Print)<br>Shannon Horlacher-grandaughter                                                                                                                                                                                                                                                                                                     |                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5930 Glen Oak Ave., Baltimore, MD 21214                  |                                                         |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.                                                                                                                                                                                                         |                                                                                | 20c. Location - City or Town, State<br>Towson, MD                                                                                                                                                                                                                                                                                                                                      |                                                     | 20d. Date<br>7/25/00                                                                                                                                      |                                                         |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                  |                                                                                                   | 22. Name and Address of Facility<br>Leonard J. Ruck Funeral Home, Inc.<br>5305 Harford Rd., Baltimore, MD 21214                                                                                                                                                                                         |                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. Endometrial Cancer<br>Due to (or as a consequence of):<br>b. Bowel Obstruction<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |                                                     | Approximate Interval Between Onset and Death                                                                                                              |                                                         |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                      |                                                                                                   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                              |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                         |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                 |                                                     | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                         |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                           |                                                     |                                                                                                                                                           |                                                         |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                   | 29b. Signature and title of certifier<br>                                                                                                                                                                            |                                                                                | 29c. License number<br>D47746                                                                                                                                                                                                                                                                                                                                                          |                                                     | 29d. Date signed (Month, Day, Year)<br>July 21, 2000                                                                                                      |                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Thomas Burke 9000 Franklin Square Drive Baltimore, MD 21237                                                                                                                                                                                                                                                                          |                                                                                                   | 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                        |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                       |                                                     |                                                                                                                                                           |                                                         |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 23341

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                         |  |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth J. Hunter</b>                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>July 20 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 3. Time of Death<br><b>4:30 P.M.</b>                                    |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b>                                                                                                                                                                                                |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4c. County of Death<br><b>Anne Arundel</b>                              |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219 18 1502</b>                                                                                                                                                                                                                                                |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br><b>June 6, 1922</b>              |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                    |  | 10a. State<br><b>Maryland</b>                                                                                                                     |  | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10c. City, Town or Location<br><b>Riviera Beach</b>                     |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |  | 10e. Street and Number<br><b>8418 Park Road</b>                                                                                                   |  | 10f. Zip Code<br><b>21122</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10g. Citizen of What Country?<br><b>U.S.</b>                            |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                 |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) _____                                                                                                                                                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>                     |  | 16b. Kind of Business/Industry<br><b>Real Estate</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                         |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>John Volkman</b>                                                                                                                                                                                                                                 |  |                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>(not available)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Harry Reese / Friend</b>                                                                                                                                                                                                                |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8418 Park Road Riviera Beach, Maryland 21122</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                         |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____                                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>                                             |  | 20c. Location - City or Town, State<br><b>7/24/00 Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21. Signature of Funeral Service Licensee<br><b>Donna M. Zancioush</b>  |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>                                                                                                                                                                               |  |                                                                                                                                                   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                         |  |
|                                               | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                               |  |                                                                                                                                                   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                        |  |                                                                                                                                                   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                         |  |
|                                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |                                                                                                                                                   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. Time of Injury<br>M _____                                                                                                                    |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28d. Describe how injury occurred                                       |  |
|                                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                            |  |                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Candace Chandler MD</b>                                                                                                                                                                                                                            |  | 29c. License number<br><b>D29209</b>                                                                                                              |  | 29d. Date signed (Month, Day, Year)<br><b>7-21-00</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                         |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Candace Chandler 8096 Edwin Raynor Blvd Pasadena MD.</b>                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                        |  | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                         |  |
|                                               | 33. Date of Death (Month, Day, Year)<br><b>July 20 2000</b>                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                         |  |





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State of Maryland / Department of Health and Mental Hygiene

00 23342

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><i>Walter H. H. Hall</i>                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   | 2. Date of Death<br>Month <i>July</i> Day <i>23</i> Year <i>2000</i>                                                                         |                                                                         | 3. Time of Death<br><i>1214 PM</i>                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><i>Fallston General Hospital</i>                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br><i>Fallston</i>                                                                                      |                                                                         | 4c. County of Death<br><i>Harford</i>                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><i>216-76-5362</i>                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                            | 7. Age (In yrs. last birthday)<br><i>90</i> Yrs. | If Under 1 Year<br>Months                                                                                                                                                                         | If Under 24 Hrs.<br>Hours                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><i>July 28, 1909</i>             | 9. Birthplace (State or Foreign Country)<br><i>England</i>    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><i>Md</i>                                                                                                                                                                                                                         | 10b. County<br><i>Harford</i>                                                                                                                                                                                                                                                                           | 10c. City, Town or Location<br><i>Bel Air</i>                                                                                                         |                                                  |                                                                                                                                                                                                   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                           |                                                                         |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br><i>2611 Conowingo Rd.</i>                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 10f. Zip Code<br><i>21015</i>                    |                                                                                                                                                                                                   | 10g. Citizen of What Country?<br><i>England</i>                                                                                              |                                                                         |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                          |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)                                                                                                                     |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>cabinet maker</i>                     |                                                  | 16b. Kind of Business/Industry<br><i>Wood Working</i>                                                                                                                                             |                                                                                                                                              |                                                                         |                                                               |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 17. Father's Name (First, Middle, Last)<br><i>Frederick J. Hall</i>                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Martha Greenwood</i>                                                                 |                                                                         |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br><i>Patricia Jones daug.</i>                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2611 Conowingo Rd. Bel Air, Md 21015</i> |                                                                         |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Bel Air Memorial Gens</i>                                                |                                                  | Date<br><i>July 27, 2000</i>                                                                                                                                                                      | 20c. Location - City or Town, State<br><i>Bel Air, Maryland</i>                                                                              |                                                                         |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br><i>Keisha S. Wells</i>                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         | 22. Name and Address of Facility<br><i>Evans Funeral Chapel<br/>3 Newport Dr. Forest Hill, Md 21050</i>                                               |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | a. <i>metastatic carcinoma of series</i><br>Due to (or as a consequence of):                                                                          |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         | Approximate Interval Between Onset and Death<br><i>months</i> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                      | b. Due to (or as a consequence of):                                                                                                                                                                                                                                                                     |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 | c. Due to (or as a consequence of):                                                                                                                                                                                                                                                                     |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| d. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                       |                                                                                                                                              |                                                                         |                                                               |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide                                                                                                                                     |                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                       | 28b. Time of Injury<br>M                         |                                                                                                                                                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                         |                                                                         | 28d. Describe how injury occurred                             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| 29b. Signature and title of certifier<br><i>Craig M. Shoughnessy MD</i>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 29c. License number<br><i>D 37078</i>                                                                                                                 |                                                  |                                                                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br><i>July 27, 2000</i>                                                                                  |                                                                         |                                                               |  |
| 30. Name and address of person who completed cause of death (Item 29a) (Type, Print)<br><i>C. SHOUGHNESSY MD 104 PLUMTREE RD. STE 115 BELAIR, MD 21014</i>                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 25 2000</i>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br><i>Penava B Sparks</i>                                                                                                                                                                                                                                                     |                                                                                                                                                       |                                                  |                                                                                                                                                                                                   |                                                                                                                                              |                                                                         |                                                               |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 23343

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                        |                                                       |                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>Benita E. Holden</b>                              |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2. Date of Death<br>Month <u>July</u> Day <u>20</u> Year <u>2000</u> |                                                                                                                                                        | 3. Time of Death<br><u>0200</u>                       |                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b> |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |                                                                                                                                                        | 4c. County of Death<br><b>City</b>                    |                                                                            |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>215-74-9064</b>                                                  |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.                     |                                                                                                                                                        | 8. Date of Birth (Month, Day, Year)<br><b>7/27/61</b> |                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, md</b>                                 |                                                                                                                                                                                                                                                                                                         | 10a. State<br><b>Md.</b>                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10b. County<br><b>City</b>                                           |                                                                                                                                                        | 10c. City, Town or Location<br><b>Baltimore</b>       |                                                                            |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  | 10d. inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                        |                                                                                | 10e. Street and Number<br><b>1435 N. Broadway St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                      | 10f. Zip Code<br><b>21213</b>                                                                                                                          |                                                       | 10g. Citizen of What Country?<br><b>USA</b>                                |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                        |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                             |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                |                                                       |                                                                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                           |                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse Aide</b>                                                                                                                                                                          |                                                                                | 16b. Kind of Business/Industry<br><b>Mariner Nursing Hm.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                      | 17. Father's Name (First, Middle, Last)<br><b>Nathaniel Sawyer</b>                                                                                     |                                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Francis Sawyer</b> |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Kennita Young Daughter</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1435 N. Broadway St. Baltimore, Md. 21213</b>                                                                                                                                                       |                                                                                | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                               |                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>                                                     |                                                       | 20c. Location - City or Town, State<br><b>7/27/00 Lansdown, md.</b>        |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                               |                                                                                                  | 22. Name and Address of Facility<br><b>Estep Brothers Funeral Ser, P. A.<br/>1300 Eutaw Place, Baltimore, Md. 21217</b>                                                                                                                                                                                 |                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <u>Enterococcus Septicemia</u><br>Due to (or as a consequence of):<br>b. <u>Thrombocytopenia</u><br>Due to (or as a consequence of):<br>c. <u>Decubitus ulcer</u><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                      | Approximate Interval Between Onset and Death<br><b>5 days</b><br><b>2 days</b><br><b>1 1/2 mo</b>                                                      |                                                       |                                                                            |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                        |                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                       |                                                                            |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                        |                                                                      | 28a. Date of Injury (Month, Day, Year)<br><b>7/27/00</b>                                                                                               |                                                       | 28b. Time of Injury<br><b>M</b>                                            |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>201 East University Pkwy Baltimore, MD 21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                           |                                                       |                                                                            |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                  | 29b. Signature and title of certifier<br><b>Vicki Hubbard, MD</b>                                                                                                                                                                                                                                       |                                                                                | 29c. License number<br><b>AV41764/35 H13184</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>20 July 00</b>                                                                                               |                                                       |                                                                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vicki Hubbard, 201 East University Pkwy Baltimore, MD 21218</b>                                                                                                                                                                                                                                                                    |                                                                                                  | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                 |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                        |                                                       |                                                                            |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23344

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William G. Hartje, Sr.

2. Date of Death

Month Day Year  
July 20 2000

3. Time of Death

5:15 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

216-32-5393

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 24, 1900

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

713 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Hardware

17. Father's Name (First, Middle, Last)

William F. C. Hartje

18. Mother's Name (First, Middle, Maiden Summa)

Rose E. Leyhe

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Hartje/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

715 Maiden Choice Lane, HV-623, Catonsville, MD

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oaklawn Cemetery

Date

7/22/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage dementia  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D51051

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2000.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Name: William Hartje expired 5:15 AM 7/20/00





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23345

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Charles I Hochberg</b>                                   |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     | 2. Date of Death<br>Month Day Year<br><b>JULY 20 2000</b>                        |                                                                                                | 3. Time of Death<br><b>0218</b>                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4e. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b> |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     | 4b. City, Town, or Location of Death<br><b>Columbia</b>                          |                                                                                                | 4c. County of Death<br><b>Howard</b>                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>570-12-4144</b>                                                         |                              | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                                 | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                                                                              |                                                                                                                                                     | 8. Date of Birth (Month, Day, Year)<br><b>8/10/1919</b>                          |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Oregon</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                             |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | 10b. County<br><b>Howard</b> |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Columbia</b>                                                                                  |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                           |  |
| 10e. Street and Number<br><b>5681 "C" Harpers Farm Rd</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               | 10f. Zip Code<br><b>21044</b>                                                                                                                       |                                                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                 |                                                           |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                     |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                           |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Stockbroker</b> |                                                                                                                                                                                               |                                                                                                                                                     | 16b. Kind of Business/Industry<br><b>Merrill Lynch</b>                           |                                                                                                |                                                           |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles I. Hochberg, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cecilia Bergida</b>                                                                         |                                                                                  |                                                                                                |                                                           |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Hochberg - Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5681 "C" Harpers Farm Rd Columbia, MD 21044</b> |                                                                                  |                                                                                                |                                                           |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Washington Cr.</b>                                                                                                                                                                                   |                                                                                                                                 |                                                                                                                                                                                               | Date<br><b>7/21/00</b>                                                                                                                              |                                                                                  | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>                                 |                                                           |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               | 22. Name and Address of Facility<br><b>Witzke Funeral Home</b><br><b>5555 Twins Knolls Rd. Columbia, Maryland 21045</b>                             |                                                                                  |                                                                                                |                                                           |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Possible Myocardial Infarction, Coronary Artery Disease, Upper GI Bleed, Renal Failure, Peripheral Vascular Disease, Diabetes Mellitus</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Possible Myocardial Infarction, Coronary Artery Disease, Upper GI Bleed, Renal Failure, Peripheral Vascular Disease, Diabetes Mellitus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                       |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                              | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                              | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                 | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                                                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                         |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                        |                                                                                  |                                                                                                |                                                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
| 29b. Signature and title of certifier<br><b>Marshall Freedman DO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               | 29c. License number<br><b>H37211</b>                                                                                                                |                                                                                  | 29d. Date signed (Month, Day, Year)<br><b>JULY 20, 2000</b>                                    |                                                           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marshall Freedman, 2 KNOLL N, COLUMBIA, MD 21045</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                                                               |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                 | 32. Registrar's Signature<br>                                                                                                                                                                 |                                                                                                                                                     |                                                                                  |                                                                                                |                                                           |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br>Sheila A. Hunter                           |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     | 2. Date of Death<br>Month Day Year<br>JULY 22 2000                                                                                                                                               |                                      | 3. Time of Death<br>0045                                                                        |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4e. Facility Name (If not institution, give street and number)<br>930 N. CARROLTON AVE |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     | 4b. City, Town, or Location of Death<br>BALTIMORE                                                                                                                                                |                                      | 4c. County of Death<br>N/A                                                                      |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br>213-62-0626                                               |                                                  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                |                                                                                                                     | 7. Age (In yrs. last birthday)<br>46 Yrs.                                                                                                                                                        |                                      | 8. Date of Birth (Month, Day, Year)<br>AUG 14, 1953                                             |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Usual Residence of Decedent                                                            |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        | 10b. County<br>N/A                               |                                                                                                                                                                                                                                                                                                               | 10c. City, Town or Location<br>Baltimore                                                                            |                                                                                                                                                                                                  |                                      |                                                                                                 | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                           |                                                                                                                                                                                                          |  |
| 10e. Street and Number<br>930 N. Carrollton Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               | 10f. Zip Code<br>21217                                                                                              |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br>USA |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                         |                                                                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                      |                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |                                                                           |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Singer |                                                                                                                                                                                                  |                                      | 16b. Kind of Business/Industry<br>Entertainment                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Irvin Bean                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br>Catherine Friday                                                                                                                            |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Catherine M. Smith/mother                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4807 Alhambra Avenue Baltimore, MD 21212                                                        |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.                                                                                                                                                                                                               |                                                                                                                     | Date<br>7/24/00                                                                                                                                                                                  |                                      | 20c. Location - City or Town, State<br>Baltimore, MD                                            |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>Dawn F. McDonald                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, MD 21228                                                                                |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. Multiple blunt force injuries<br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                  | 28a. Date of Injury (Month, Day, Year)<br>Femur 7-22-2000                                                                                                                                                                                                                                                     |                                                                                                                     | 28b. Time of Injury<br>unknown M                                                                                                                                                                 |                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                    | 28d. Describe how injury occurred<br>Subject was struck with blunt object |                                                                                                                                                                                                          |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Residence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        |                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>930 N. Carrollton Baltimore City, Maryland                                                                                                                                                                                    |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                        |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 29b. Signature and title of certifier<br>Stephen A. Madetz, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     | 29c. License number<br>O.C.M.E                                                                                                                                                                   |                                      | 29d. Date signed (Month, Day, Year)<br>JULY 22, 2000                                            |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                               |                                                                                                                     |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        | 31. Date filed (Month, Day, Year)<br>JUL 25 2000 |                                                                                                                                                                                                                                                                                                               | 32. Registrar's Signature<br>Dawn B. Sparks                                                                         |                                                                                                                                                                                                  |                                      |                                                                                                 |                                                                                                    |                                                                           |                                                                                                                                                                                                          |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 23347

IMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G185 7-25-00 WR.

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                           |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                             |  |                                                          |                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                        |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Michael Hagicostas</b>                                                                                                                                                                     |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Date of Death<br>Month <b>July</b> Day <b>17</b> Year <b>2000</b>                                                                                                                                        |  |                                                          |                                                                                                                                                                | 3. Time of Death<br><b>12:00 Noon</b>                                                                                                                                                                                                                                                                                  |  |  |
|                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>643 South Oldham Street</b>                                                                                                                                          |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                                    |  |                                                          |                                                                                                                                                                | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                                                                                                                                      |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>217-90-3995</b>                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>31</b> Yrs.                                                                                                                                                            |  | 8. Date of Birth (Month, Day, Year)<br><b>10/09/1968</b> |                                                                                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                                                                                                                                                                                                                                            |  |  |
|                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                                                                                                                                                                               |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br><b>MD</b>                                                                                                                                                                                     |  | 10b. County<br><b>Baltimore</b>                          |                                                                                                                                                                | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                                                        |  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                | 10a. State<br><b>MD</b>                                                                                                                                                                                                                   |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10b. County<br><b>Baltimore</b>                                                                                                                                                                             |  |                                                          |                                                                                                                                                                | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                                                        |  |  |
|                                                                                                                                                                                                                                                                                    | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                            |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>643 Oldham Street</b>                                                                                                                                                          |  |                                                          |                                                                                                                                                                | 10f. Zip Code<br><b>21224</b>                                                                                                                                                                                                                                                                                          |  |  |
|                                                                                                                                                                                                                                                                                    | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                               |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                              |  |                                                          |                                                                                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                      |  |  |
|                                                                                                                                                                                                                                                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                             |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                     |  |                                                          |                                                                                                                                                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>2+</b>                                                                                                                                                                              |  |  |
|                                                                                                                                                                                                                                                                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Plumber</b>                                                                                                               |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 16b. Kind of Business/Industry<br><b>Self Employed</b>                                                                                                                                                      |  |                                                          |                                                                                                                                                                | 17. Father's Name (First, Middle, Last)<br><b>Paul Hagicostas</b>                                                                                                                                                                                                                                                      |  |  |
|                                                                                                                                                                                                                                                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Pandelis</b>                                                                                                                                                            |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>Paul Hagicostas Father</b>                                                                                                                           |  |                                                          |                                                                                                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>643 Oldham Street Baltimore, MD 21224</b>                                                                                                                                                                          |  |  |
|                                                                                                                                                                                                                                                                                    | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)     |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>                                                                                                           |  |                                                          |                                                                                                                                                                | 20c. Location - City or Town, State<br><b>07/21 Baltimore, MD</b>                                                                                                                                                                                                                                                      |  |  |
|                                                                                                                                                                                                                                                                                    | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                             |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 22. Name and Address of Facility<br><b>Bradley Ashton Matthews Funeral Home, Inc.<br/>2134 Willow Spring RD Baltimore, MD 21222</b>                                                                         |  |                                                          |                                                                                                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>NARCOTIC INTOXICATION</b>                                                                              |  |  |
|                                                                                                                                                                                                                                                                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>NARCOTIC INTOXICATION</b> |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |                                                          |                                                                                                                                                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                  |  |  |
|                                                                                                                                                                                                                                                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                        |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                           |  |                                                          |                                                                                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b> |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined |                                                                                                                                                                                                                                           |  |                                                                            | 28a. Date of Injury (Month, Day, Year)<br><b>Found: 7-17-00</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                             |  |                                                          | 28b. Time of Injury<br><b>Found: 11:45</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                        |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                        |                                                                                                                                                                                                                                           |  |                                                                            | 28d. Describe how injury occurred<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |  |                                                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RESIDENCE</b>                                                     |                                                                                                                                                                                                                                                                                                                        |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>643 S. OLDHAM ST. BALTIMORE, MD.</b>                                                                                                                                                            |                                                                                                                                                                                                                                           |  |                                                                            | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                             |  |                                                          | 29b. Signature and title of certifier<br>                                                                                                                      |                                                                                                                                                                                                                                                                                                                        |  |  |
| 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |  |                                                                            | 29d. Date signed (Month, Day, Year)<br><b>July 18, 2000</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                             |  |                                                          | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201</b> |                                                                                                                                                                                                                                                                                                                        |  |  |
| State<br>Registrar                                                                                                                                                                                                                                                                 | 31. Date filed (Month, Day, Year)<br><b>JUL 26 2000</b>                                                                                                                                                                                   |  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 32. Registrar's Signature<br>                                                                                                                                                                               |  |                                                          |                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                        |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23348

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADELE HYLAND

2. Date of Death

07 - 20 - 00

3. Time of Death

11:10 AM

4a. Facility Name (If not Institution, give street and number)

Rock Glen Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216.10.8559

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

May 8, 1920 Washington DC

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Fairhaven Court

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Walter Brotzman

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor A. Hedrick

19a. Informant's Name/Relationship (Type, Print)

Harriett Goodmuth/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Fairhaven Ct. Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Pk. 7/24

Date

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home  
7250 Washington Blvd. Elkridge, MD 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

b.

Metastatic Breast carcinoma

Due to (or as a consequence of):

1 yr

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25044

29d. Date signed (Month, Day, Year)

7/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. R. Hoffman MD

2717 Hammond Ferry Rd  
Baltimore, MD 21227State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23349

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |  |                                                                            |                                                                                                                                                                                                                                                                                                                       |                                                            |                          |                                                           |                                                                                                                                                                                                 |                                                        |                                                             |                                                 |                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>(Medical<br>Examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1. Decedent's Name (First, Middle, Last)<br><b>DARRON C. JONES</b>                            |  |                                                                            |                                                                                                                                                                                                                                                                                                                       | 2. Date of Death<br>Month Day Year<br><b>July 23, 2000</b> |                          |                                                           |                                                                                                                                                                                                 | 3. Time of Death<br><b>4:15 PM</b>                     |                                                             |                                                 |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS HOSPICE</b> |  |                                                                            |                                                                                                                                                                                                                                                                                                                       | 4b. City, Town, or Location of Death<br><b>BALTO</b>       |                          |                                                           |                                                                                                                                                                                                 | 4c. County of Death<br><b>N/A</b>                      |                                                             |                                                 |                                                                                                                                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>217-68-4177</b>                                               |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                       | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.           |                          | 8. Date of Birth (Month, Day, Year)<br><b>JAN 5, 1960</b> |                                                                                                                                                                                                 | 9. Birthplace (State or Foreign Country)<br><b>MD.</b> |                                                             |                                                 |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                   |  |                                                                            |                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD.</b>                                   |                          |                                                           |                                                                                                                                                                                                 | 10b. County<br><b>N/A</b>                              |                                                             | 10c. City, Town or Location<br><b>BALTIMORE</b> |                                                                                                                                         |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |  |                                                                            | 10e. Street and Number<br><b>1826 CHILTON ST.</b>                                                                                                                                                                                                                                                                     |                                                            |                          |                                                           | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                   |                                                        | 10g. Citizen of What Country?<br><b>U.S.A.</b>              |                                                 |                                                                                                                                         |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |  |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                     |                                                            |                          |                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                        |                                                             |                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |  |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>                                                                                                                                                                                           |                                                            |                          |                                                           | 16b. Kind of Business/Industry<br><b>MARYLAND CUP CO.</b>                                                                                                                                       |                                                        |                                                             |                                                 |                                                                                                                                         |  |
| 17. Father's Name (First, Middle, Last)<br><b>BERNARD BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |  |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BARBARA MASSENBURG</b>                                                                                                                                                                                                                                        |                                                            |                          |                                                           |                                                                                                                                                                                                 |                                                        |                                                             |                                                 |                                                                                                                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>BARBARA BROWN/mother</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |  |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1826 CHILTON ST - BALTO, MD. 21218</b>                                                                                                                                                                            |                                                            |                          |                                                           |                                                                                                                                                                                                 |                                                        |                                                             |                                                 |                                                                                                                                         |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |  |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cem</b>                                                                                                                                                                                                                         |                                                            |                          |                                                           | Date<br><b>7/23/00</b>                                                                                                                                                                          |                                                        | 20c. Location - City or Town, State<br><b>Woodlawn, MD.</b> |                                                 |                                                                                                                                         |  |
| 21. Signature of Funeral Service Licensee<br><b>Quenell Comarrie</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |  |                                                                            | 22. Name and Address of Facility<br><b>BETTS FUNERAL HOME</b>                                                                                                                                                                                                                                                         |                                                            |                          |                                                           | 1129 N. CAROLINE ST. BALTO, MD 21213                                                                                                                                                            |                                                        |                                                             |                                                 |                                                                                                                                         |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>Dilated Cardiomyopathy</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Due to (or as a consequence of):</b><br><b>Due to (or as a consequence of):</b> |                                                                                               |  |                                                                            |                                                                                                                                                                                                                                                                                                                       |                                                            |                          |                                                           | Approximate Interval Between Onset and Death                                                                                                                                                    |                                                        |                                                             |                                                 |                                                                                                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Seizure Disorder</b><br><b>Alcohol Abuse</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |  |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                      |                                                            |                          |                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                           |                                                        |                                                             |                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |  |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |                                                            |                          |                                                           |                                                                                                                                                                                                 |                                                        |                                                             |                                                 |                                                                                                                                         |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |  |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                |                                                            | 28b. Time of Injury<br>M |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                |                                                        | 28d. Describe how injury occurred                           |                                                 |                                                                                                                                         |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |  |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                          |                                                            |                          |                                                           |                                                                                                                                                                                                 |                                                        |                                                             |                                                 |                                                                                                                                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                    |                                                                                               |  |                                                                            | 29b. Signature and title of certifier<br><b>Dr. [Signature]</b>                                                                                                                                                                                                                                                       |                                                            |                          |                                                           | 29c. License number<br><b>D40854</b>                                                                                                                                                            |                                                        | 29d. Date signed (Month, Day, Year)<br><b>July 24, 2000</b> |                                                 |                                                                                                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |  |                                                                            | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                               |                                                            |                          |                                                           | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                 |                                                        |                                                             |                                                 |                                                                                                                                         |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 23350

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------|----------------------------------------------|----------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><u>Cynthia Jones</u>                                |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   | 2. Date of Death<br>Month <u>July</u> Day <u>23</u> Year <u>2000</u> |                                                                                                                                                                                                          | 3. Time of Death<br><u>4:28 AM</u>                     |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not Institution, give street and number)<br><u>Johns Hopkins Hospital</u> |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>             |                                                                                                                                                                                                          | 4c. County of Death<br><u>NA</u>                       |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><u>218-74-5093</u>                                                 |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br><u>39</u> Yrs.                     |                                                                                                                                                                                                          | 8. Date of Birth (Month, Day, Year)<br><u>05-09-61</u> |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><u>MD</u>                                           |                                                                                                                                                                                                                                                                                                         | 10a. State<br><u>MD</u>                                                        |                                                                                                                                                                                                   | 10b. County<br><u>NA</u>                                             |                                                                                                                                                                                                          | 10c. City, Town or Location<br><u>Baltimore</u>        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 | 10e. Street and Number<br><u>2417 Llewelyn Avenue</u>                                                                                                                                                                                                                                                   |                                                                                | 10f. Zip Code<br><u>21213</u>                                                                                                                                                                     |                                                                      | 10g. Citizen of What Country?<br><u>USA</u>                                                                                                                                                              |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                                                                                                                                  |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>11th Grade</u><br>College (1-4 or 5+) <u>NA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Factory worker</u>                                                                                                                                                                      |                                                                                | 16b. Kind of Business/Industry<br><u>Temporary Service</u>                                                                                                                                        |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 17. Father's Name (First, Middle, Last)<br><u>Nathaniel Jones, Sr.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Marie Medley</u>                                                                                                                          |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Shiela Mitz</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>5505 Burkneil Road Baltimore, Maryland 21206</u>                                              |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>King Mem. Pk. Cem.</u>                                                                                                                                                                                                     |                                                                                | 20c. Location - City or Town, State<br><u>07-27-2000 Randallstown, MD</u>                                                                                                                         |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 21. Signature of Funeral Service Licensee<br><u>Gabriele Wok</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br><u>Baltimore, Maryland 21202</u><br><u>WM.C. March FH 1101 E. North Avenue</u>                                                                                |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>Metastatic NSCLC (Non-small cell lung carcinoma)</u><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><u>~ 4 months.</u></td> </tr> <tr> <td>b. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____<br/>Due to (or as a consequence of):</td> </tr> </table> |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Metastatic NSCLC (Non-small cell lung carcinoma)</u><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><u>~ 4 months.</u> | b. _____<br>Due to (or as a consequence of): | c. _____<br>Due to (or as a consequence of): | d. _____<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | a. <u>Metastatic NSCLC (Non-small cell lung carcinoma)</u><br>Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><u>~ 4 months.</u>                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | b. _____<br>Due to (or as a consequence of):                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | c. _____<br>Due to (or as a consequence of):                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | d. _____<br>Due to (or as a consequence of):                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Methicillin Resistant Staphylococcus Aureus Pneumonia</u><br><u>Hepatitis C</u><br><u>Nephrotic Syndrome.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                | 28b. Time of Injury<br><u>M</u>                                                                                                                                                                   |                                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                |                                                                                                                                                                                                   |                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                             |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 29b. Signature and title of certifier<br><u>Dr. Brian McClune MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 29c. License number<br><u>RES-000</u>                                                                                                                                                             |                                                                      | 29d. Date signed (Month, Day, Year)<br><u>July 23, 2000</u>                                                                                                                                              |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Dr. Brian McClune, MD Johns Hopkins Hospital 600 N. Wolfe Street</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |
| 31. Date filed (Month, Day, Year)<br><u>JUL 25 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                 | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                        |                                                                                                                                                                                                                                   |                                                                                                |                                                                    |                                              |                                              |                                              |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23351

AMEND#19B PER INFMNT G788 10-19 2000 JAB  
amended item 18 per fh g785 wj 7-25-00

## Certificate of Death

Reg. No.

|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Helen Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>July 22, 2000                                                                                                                                               |                                                                                                                                             |                                                                                      |                                                                  | 3. Time of Death<br>2:15 PM                                                                        |  |
|                                                  | 4a. Facility Name (If not institution, give street and number)<br>Vantage House                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Columbia                                                                                                                                                  |                                                                                                                                             |                                                                                      |                                                                  | 4c. County of Death<br>Howard County                                                               |  |
| Funeral<br>Director                              | 5. Social Security Number<br>480-05-4710                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>95 Yrs.                                                                                                                                                         |                                                                                                                                             | 8. Date of Birth (Month, Day, Year)<br>10-29-1904                                    |                                                                  | 9. Birthplace (State or Foreign Country)<br>Iowa                                                   |  |
|                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director              | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. County<br>Howard                                                                                                                                                                                                                                                                                   |  | 10c. City, Town or Location<br>Columbia                                                                                                                                                           |                                                                                                                                             |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                  | 10e. Street and Number<br>5400 Vantage Point Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br>21044                                                                                                                                                                            |                                                                                                                                             | 10g. Citizen of What Country?<br>USA                                                 |                                                                  |                                                                                                    |  |
|                                                  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                             |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerical                                                                             |                                                                                                                                             |                                                                                      | 16b. Kind of Business/Industry<br>State Department               |                                                                                                    |  |
|                                                  | 17. Father's Name (First, Middle, Last)<br>Alfred Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sophia Malm                                                                                                                                  |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner    | 19a. Informant's Name/Relationship (Type, Print)<br>Floyd Johnson (Brother)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14064 S.W. Goodall Rd. Oswego, IL 97073<br>LAKE OSWEGO, OR. 97034                                |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Springdale Cemetery                                                                                                                                                                                                           |  | Date<br>7/27/00                                                                                                                                                                                   |                                                                                                                                             | 20c. Location - City or Town, State<br>Clinton, Iowa                                 |                                                                  |                                                                                                    |  |
|                                                  | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Sterling-Ashton-Schwab Funeral Home, Inc.<br>736 Edmondson Ave. Catonsville, MD 21228                                                                         |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Alzheimers Disease</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                               |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M                                                                                                                                                                          |                                                                                                                                             | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                  |  |
|                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
| State<br>Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 29b. Signature and title of certifier<br>William Flowers MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 29c. License number<br>V20789                                                                                                                                                                     |                                                                                                                                             | 29d. Date signed (Month, Day, Year)<br>July 24, 2000                                 |                                                                  |                                                                                                    |  |
|                                                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>William Flowers MD 505 Little Patuxent Columbia MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |
| 32. Registrar's Signature                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23352

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br>NANCY A KOSMICKY                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br>July 21 2000 |                                                                                      | 3. Time of Death<br>352 PM                           |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br>Franklin Square Hospital center |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br>Rosedale   |                                                                                      | 4c. County of Death<br>Baltimore                     |                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br>217-26-9699                                                          |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>70 Yrs.          |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>April 28 1930 |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br>PA                                                    |                                                                                                                                                                                                                                                                                                         | 10a. State<br>MD                                                               |                                                                                                                                                                                                          | 10b. County<br>Baltimore                           |                                                                                      | 10c. City, Town or Location<br>Baltimore             |                                                |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                      |                                                                                | 10e. Street and Number<br>7920 Bank Street                                                                                                                                                               |                                                    | 10f. Zip Code<br>21224                                                               |                                                      | 10g. Citizen of What Country?<br>USA           |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |                                                      |                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (13-16) 5+                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                  |                                                                                | 16b. Kind of Business/Industry<br>own home                                                                                                                                                               |                                                    |                                                                                      |                                                      |                                                |  |
| 17. Father's Name (First, Middle, Last)<br>William Straw                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Eva Detrich                                                                                                                                         |                                                    |                                                                                      |                                                      |                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Raymond Kosmicky /husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7920 Bank Street Baltimore MD 21224                                                                     |                                                    |                                                                                      |                                                      |                                                |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gardens of Faith                                                                                                                                                                                                              |                                                                                | 20c. Date<br>7/25/2000                                                                                                                                                                                   |                                                    | 20d. Location - City or Town, State<br>Rossville MD                                  |                                                      |                                                |  |
| 21. Signature of Funeral Service Licensee<br>R. Terry Connelly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br>Connelly Funeral Home of Essex<br>300 Mace Ave. Baltimore MD 21221                                                                                                   |                                                    |                                                                                      |                                                      |                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Promyelocytic Leukemia<br>Due to (or as a consequence of):<br>b. Disseminated Intravascular Coagulation<br>Due to (or as a consequence of):<br>c. Intracranial Hemorrhage<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                | Approximate Interval Between Onset and Death<br>2 weeks                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                    |                                                                                      |                                                      |                                                |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                    |                                                                                      |                                                      |                                                |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |                                                |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                                 |                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how injury occurred              |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |                                                |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                | 29b. Signature and title of certifier<br>Jeanette Krolkowski, D.O.                                                                                                                                       |                                                    | 29c. License number<br>RD 203315                                                     |                                                      | 29d. Date signed (Month, Day, Year)<br>7/21/00 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Dr Jeanette Krolkowski 9000 Franklin Square Drive Baltimore MD 21237                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                | 31. Date filed (Month, Day, Year)<br>JUL 23 2000                                                                                                                                                         |                                                    |                                                                                      |                                                      | 32. Registrar's Signature<br>Hanks             |  |

ORIGINAL



100-100000-100000

100-100000-100000



Rachel Marie Kreiner

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State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27, per me G788 10/18/00 yf

## Certificate of Death

Reg. No.

00 23353

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br>Rachel Marie Kreiner                    |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               | 2. Date of Death<br>Month Day Year<br>July 22 2000 |                                                      |                                                                  |                                                                                                                                                                                                          | 3. Time of Death<br>11:20 A.M.   |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4a. Facility Name (If not institution, give street and number)<br>1027 Regina Drive |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br>Arbutus    |                                                      |                                                                  |                                                                                                                                                                                                          | 4c. County of Death<br>Baltimore |                                                                                                                                                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br>217-57-8821                                            | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br>Yrs. Months Days<br>3 7 | 8. Date of Birth (Month, Day, Year)<br>April 29, 2000                                                                                                                                                                                                                                                         |                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Usual Residence of Decedent                                                         |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 10a. State<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                     | 10b. County<br>Baltimore                                                                                                                              |                                                           | 10c. City, Town or Location<br>Arbutus                                                                                                                                                                                                                                                                        |                                                    |                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                  |                                                                                                                                                        |  |
| 10e. Street and Number<br>1027 Regina Drive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                     |                                                                                                                                                       |                                                           | 10f. Zip Code                                                                                                                                                                                                                                                                                                 |                                                    | 10g. Citizen of What Country?<br>U.S.A.              |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                              |                                                    |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: white |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                     |                                                                                                                                                       |                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>N/A                                                                                                                                                                                              |                                                    |                                                      | 16b. Kind of Business/Industry<br>N/A                            |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 17. Father's Name (First, Middle, Last)<br>Kenneth F. Kreiner, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                       |                                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>Susan (Byrnes) Kreiner                                                                                                                                                                                                                                   |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Susan & Kenneth Kreiner-Parents                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                     |                                                                                                                                                       |                                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1027 Regina Drive Arbutus, Maryland 21227                                                                                                                                                                    |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                                                                                                       |                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Louis Catholic Cemetery                                                                                                                                                                                                         |                                                    | Date<br>7-25-00                                      |                                                                  | 20c. Location - City or Town, State<br>Clarksville, Maryland                                                                                                                                             |                                  |                                                                                                                                                        |  |
| 21. Signature of Funeral Service Licensee<br>▶                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                     |                                                                                                                                                       |                                                           | 22. Name and Address of Facility<br>Witzke Funeral Home Inc<br>5555 Twin Knolls Road Columbia, Maryland 21045                                                                                                                                                                                                 |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. SUDDEN INFANT DEATH SYNDROME (SIDS)<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                                                                                     |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  | Approximate Interval Between Onset and Death                                                                                                           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               |                                                    |                                                      |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                  |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               |                                                    |                                                      |                                                                  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                |                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     |                                                                                                                                                       |                                                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                               |                                                                                     |                                                                                                                                                       |                                                           | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                         |                                                    | 28b. Time of Injury<br>M                             |                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                  | 28d. Describe how injury occurred                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                                                                                                       |                                                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                        |                                                    |                                                      |                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                             |                                  |                                                                                                                                                        |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                        |                                                                                     |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 29b. Signature and title of certifier<br>▶ Theodore M. King                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                     |                                                                                                                                                       |                                                           | 29c. License number<br>O.C.M.E.                                                                                                                                                                                                                                                                               |                                                    |                                                      |                                                                  | 29d. Date signed (Month, Day, Year)<br>July 23, 2000                                                                                                                                                     |                                  |                                                                                                                                                        |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                     |                                                                                                                                                       |                                                           |                                                                                                                                                                                                                                                                                                               |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                     |                                                                                                                                                       |                                                           | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                                                                                                                        |                                                    |                                                      |                                                                  |                                                                                                                                                                                                          |                                  |                                                                                                                                                        |  |

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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>AIMA M. KINLEY</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  | 2. Date of Death<br>Month Day Year<br><b>JULY 18 2000</b>                                                                                                                                         |                                                                             |                                                                      |                                                                         | 3. Time of Death<br><b>7:45pm</b>                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not Institution, give street and number)<br><b>GENESIS LONG GREEN</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                          |                                                                             |                                                                      |                                                                         | 4c. County of Death<br><b>N/A</b>                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><b>172-38-3919</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                                                                                                                                                  |                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>09/02/1911</b>             |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>INDIANA</b>                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. County<br><b>N/A</b>                                                                                                                             |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                                   |                                                                             |                                                                      |                                                                         | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br><b>115 EAST MELROSE AVE</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  | 10f. Zip Code<br><b>21212</b>                                                                                                                                                                     |                                                                             | 10g. Citizen of What Country?<br><b>USA</b>                          |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                             |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12YRS</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>                                                                     |                                                                             |                                                                      | 16b. Kind of Business/Industry<br><b>HOMEMAKER</b>                      |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br><b>JOHN EMIL ANDERSON</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |  |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY JANE WITTE</b> |                                                                      |                                                                         |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>SUSAN M. NIEMEYER (DAUGHTER)</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>405 OVERHILL RD. BALTO., MD. 21210</b>                                                        |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                    |  |                                                                                                                                                       |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CREMATORY</b>                                                                                            |                                                                             | 20c. Location - City or Town, State<br><b>07/20/2000 BALTO., MD.</b> |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |  | 22. Name and Address of Facility<br><b>HENRY W. JENKINS &amp; SONS CO.<br/>4905 YORK RD. BALTO., MD. 21212.</b>                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>Cerebrovascular accident</b><br>Due to (or as a consequence of):<br>b. <b>Anaemia</b><br>Due to (or as a consequence of):<br>c. <b>Degenerative Joint Disease</b><br>Due to (or as a consequence of):<br>d. <b>Dementia</b> |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23b. Approximate Interval Between Onset and Death<br><b>17/25</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 23b. Did tobacco use contribute to the causa of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 28a. Date of Injury (Month, Day, Year)<br><b></b>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 28d. Describe how injury occurred<br><b></b>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b></b>                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 29c. License number<br><b>D31464</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 29d. Date signed (Month, Day, Year)<br><b>7/19/00</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHOAB HASHMI M.D. 821 NORTH EUTAW ST. SUITE 308 BALTO., MD. 21201.</b>                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |                                                                             |                                                                      |                                                                         |                                                                                                    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



00-3965-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

HORACE

State of Maryland / Department of Health and Mental Hygiene

00 23355

KELLY AMEND ITEMS: #23 PART I, II, 27 PER MEO Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                            |                                                                                                                                                                                                   |                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>HORACE P. KELLY</b>                             |                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>JULY 18, 2000</b> |                                                                                                                                                                                                   | 3. Time of Death<br><b>3:40P.M.</b>                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>300 E. MADISON STREET</b> |                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                                                                                                                                                                                   | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>213-52-1507</b>                                                |                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>50</b>                |                                                                                                                                                                                                   | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 30, 1950</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |                                                                                                                                                                                                             | 10a. State<br><b>MARYLAND</b>                                              |                                                                                                                                                                                                                                                                                                         | 10b. County<br><b>N/A</b>                                  |                                                                                                                                                                                                   | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                | 10e. Street and Number<br><b>1220 N. CURLEY ST.</b>                                                                                                                                                         |                                                                            | 10f. Zip Code<br><b>21213</b>                                                                                                                                                                                                                                                                           |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                    |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                            |                                                            | 14. Race - American Indian, Black, White, etc.<br><b>Afro AMERICAN</b>                                                                                                                            |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b><br>College (1-4 or 5+) <b>TRUCK DRIVER</b>                                                                                                                                                                                                                                                                        |                                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>                                                                            |                                                                            | 16b. Kind of Business/Industry<br><b>TRUCK CO.</b>                                                                                                                                                                                                                                                      |                                                            |                                                                                                                                                                                                   |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>WALTER KELLY</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALICE</b>                                                                                                                                                                                                                                       |                                                            |                                                                                                                                                                                                   |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DENISE KELLY (WIFE)</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1220 N. CURLEY ST. BALTO, MD. 21213</b>                                                                                                                                                             |                                                            |                                                                                                                                                                                                   |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>                                                                                                          |                                                                            | 20c. Location - City or Town, State<br><b>BALTIMORE, MD.</b>                                                                                                                                                                                                                                            |                                                            | 20d. Date<br><b>JULY 21, 2000</b>                                                                                                                                                                 |                                                             |  |
| 21. Signature of Funeral Service Licensee<br><i>Bernadine B. Scruggs</i>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                | 22. Name and Address of Facility<br><b>CALVIN B. SCRUGGS FUNERAL HOME</b><br><b>1412 E. PRESTON ST. BALTIMORE, MD. 21213</b>                                                                                |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                            |                                                                                                                                                                                                   |                                                             |  |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HYPERTENSIVE CARDIOVASCULAR DISEASE COMPLICATED BY DIARRHEA AND VOMITING</b>                                                                                                                                 |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                            | 23c. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                   |                                                            | 23d. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                |                                                             |  |
| 23e. Pert 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CHRONIC NARCOTISM</b>                                                                                                                                                                                        |                                                                                                | 23f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.           |                                                                            | 23g. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                       |                                                            | 23h. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                                                             |  |
| 24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.<br><b>CHRONIC NARCOTISM</b>                                                                                                                                                                                                                                                                                |                                                                                                | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                           |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>CELL</b> |                                                            |                                                                                                                                                                                                   |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                      |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                         |                                                            | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                       |                                                             |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                      |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                            |                                                                                                                                                                                                   |                                                             |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                | 29b. Signature and title of certifier<br><i>J. M. Titus</i>                                                                                                                                                 |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                  |                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 19, 2000</b>                                                                                                                                       |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JACK M. TITUS, M.D.</b>                                                                                                                                                                                                                                                                                                           |                                                                                                | 31. Date filed (Month, Day, Year)<br><b>AUG 10 2000</b>                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                            |                                                                                                                                                                                                   |                                                             |  |
| 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                | 33. Date of Death (Month, Day, Year)<br><b>JULY 18, 2000</b>                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                            |                                                                                                                                                                                                   |                                                             |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23356

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCE

KLAFF

2. Date of Death

Month Day Year  
July 21 2000

3. Time of Death

2:55 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-12-8337

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

AUG. 6, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7937 WINTERSET AVENUE

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

PROPRIETOR

16b. Kind of Business/Industry

DRY GOODS

17. Father's Name (First, Middle, Last)

ISADORE

SHOCKET

18. Mother's Name (First, Middle, Maiden Surname)

SARA

HARRIS

19a. Informant's Name/Relationship (Type, Print)

SHARON BENUS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7937 WINTERSET AVENUE - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MIKRO KODESH CEMETERY

Date

7/23/00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Non-insulin dependent Diabetes,  
End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

RES000

29d. Date signed (Month, Day, Year)

July 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Grand 2401 West Belvedere Ave Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Pt. known as Florence Klaff

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

W.F.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23357

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>GERT RUDE</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 2. Date of Death<br>Month <b>JULY</b> Day <b>23</b> Year <b>2000</b>                                                                                                                                                                                                                        |                                                            | 3. Time of Death<br><b>11:12 A.M.</b>                                                                                                                                                        |                                              |
| 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                                                                       |                                                                            | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                               |                                                            | 4c. County of Death<br><b>N/A</b>                                                                                                                                                            |                                              |
| 5. Social Security Number<br><b>217-01-7390</b>                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>102</b> Yrs.                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>MAY 19, 1898</b> | 9. Birthplace (State or Foreign Country)<br><b>Ua.</b>                                                                                                                                       |                                              |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |
| 10a. State<br><b>md.</b>                                                                                                                                                                                                                                                                                                                                                                                                  | 10b. County<br><b>N/A</b>                                                  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                                                                                                                             |                                                            | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               |                                              |
| 10e. Street and Number<br><b>2040 E. LANVALE ST.</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 10f. Zip Code<br><b>21213</b>                                                                                                                                                                                                                                                               |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |                                              |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                              |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4TH</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                  |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC WORKER</b>                                                                                                                                                         |                                                            | 16b. Kind of Business/Industry<br><b>PRIVATE HOME</b>                                                                                                                                        |                                              |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES KENNY</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>WILLIE ANNA OWENS</b>                                                                                                                                                                                                               |                                                            |                                                                                                                                                                                              |                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CORRINE FLEMING/daughter</b>                                                                                                                                                                                                                                                                                                                                       |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2040 E. LANVALE ST - BALTO, MD 21213</b>                                                                                                                                                |                                                            |                                                                                                                                                                                              |                                              |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND NAT'L MEM PL</b>                                                                                                                                                                                      |                                                            | 20c. Location - City or Town, State<br><b>7/28/00 Laurel, md</b>                                                                                                                             |                                              |
| 21. Signature of Funeral Service Licensee<br><b>Gwendolyn Cromartie</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br><b>BETTS FUNERAL HOME<br/>1129 N. CAROLINE ST - BALTO, MD 21213</b>                                                                                                                                                                                     |                                                            |                                                                                                                                                                                              |                                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)<br><b>CARDIAC ARRHYTHMIA</b>                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              | <b>UNKNOWN</b>                               |
| Due to (or as a consequence of):<br><b>HYPOKALEMIA</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              | <b>UNKNOWN</b>                               |
| Due to (or as a consequence of):<br><b>ASPIRATION PNEUMONIA</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              | <b>4 days</b>                                |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                            |                                                                                                                                                                                              |                                              |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            |                                                                                                                                                                                              |                                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                            | 28b. Time of Injury<br>M                                                                                                                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |                                                            | 28d. Describe how injury occurred                                                                                                                                                            |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |
| 29b. Signature and title of certifier<br><b>John Lucian Davis Jr. MD</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 29c. License number<br><b>RES-000</b>                                                                                                                                                                                                                                                       |                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 23, 2000</b>                                                                                                                                  |                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN LUCIAN DAVIS, JR MD 600 NORTH WOLFE STREET BALTIMORE 21287</b>                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                              |

1870  
The following is a list of the  
names of the persons who  
were present at the  
meeting of the  
Board of Directors  
of the  
Company held on  
the 1st day of  
January 1870.  
The names of the  
persons who were  
present at the  
meeting of the  
Board of Directors  
of the  
Company held on  
the 1st day of  
January 1870.  
The names of the  
persons who were  
present at the  
meeting of the  
Board of Directors  
of the  
Company held on  
the 1st day of  
January 1870.

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State of Maryland / Department of Health and Mental Hygiene

00 23358

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>Myung S. Lee</b>                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>2000</b> |                                                                                      |                                                         |                                                                                                                                                                                                          | 3. Time of Death<br><b>11:30 A.M.</b>                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Hospice Center</b> |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>Towson</b>                |                                                                                      |                                                         |                                                                                                                                                                                                          | 4c. County of Death<br><b>Baltimore</b>                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>444-62-8017</b>                                                   |                                                                                                                                                                                                                                                                                                                        | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.                     |                                                                                      | 8. Date of Birth (Month, Day, Year)<br><b>5/17/1939</b> |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>Seoul, Korea</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Usual Residence of Decedent                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 10a. State<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                        |                                                                                | 10c. City, Town or Location<br><b>Perry Hall</b>                                                                                                                                                 |                                                                      |                                                                                      |                                                         | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                                 |  |
| 10e. Street and Number<br><b>3919 A. Klausmier Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                | 10f. Zip Code<br><b>21236</b>                                                                                                                                                                    |                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                  |                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                  |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                      |                                                                                      |                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                  |                                                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>                                                                        |                                                                      |                                                                                      |                                                         | 16b. Kind of Business/Industry<br><b>Health Care</b>                                                                                                                                                     |                                                                 |  |
| 17. Father's Name (First, Middle, Last)<br><b>Sah Ann Moon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Duk Ho Kim</b>                                                                                                                           |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kun H Lee - Husband</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3919 A. Klausmier Road Perry Hall, Md 21236</b>                                              |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                         |                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crestlawn Memorial Park</b>                                                                                                                                                                                                               |                                                                                | 20c. Date<br><b>7/21/00</b>                                                                                                                                                                      |                                                                      | 20d. Location - City or Town, State<br><b>Marriottsville, Md</b>                     |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                | 22. Name and Address of Facility<br><b>Witzke Funeral Home<br/>5555 Twins Knolls Road Columbia, Md 21045</b>                                                                                     |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lymphoma</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>1 year</b> |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         | Approximate Interval Between Onset and Death<br><b>1 year</b>                                                                                                                                            |                                                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                                 |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                  |                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                 |                                                                                | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |                                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                         | 28d. Describe how injury occurred                                                                                                                                                                        |                                                                 |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                               |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                | 29c. License number<br><b>D25205</b>                                                                                                                                                             |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>July 19, 2000</b>                          |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>W. A. R. Taylor, 6301 N. Charles St. Balts. Md 21208</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                  |                                                                      |                                                                                      |                                                         |                                                                                                                                                                                                          |                                                                 |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 23359

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                       |                                                  |                                                                                                                                                                                |                                                            |                                                                                                                                                    |                                                                                                |                                                                                                                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Francis Hal Leishure</b>                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                       |                                                  |                                                                                                                                                                                | 2. Date of Death<br>Month Day Year<br><b>July 22, 2000</b> |                                                                                                                                                    | 3. Time of Death<br><b>3:30 AM</b>                                                             |                                                                                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>63 Wise Avenue</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                       |                                                  |                                                                                                                                                                                | 4b. City, Town, or Location of Death<br><b>Dundalk</b>     |                                                                                                                                                    | 4c. County of Death<br><b>Baltimore</b>                                                        |                                                                                                                                                                                                 |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>214-26-8876</b>                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                       | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs. |                                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>10-06-1929</b>   |                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |                                                                                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                                                       | 10b. County<br><b>Baltimore</b>                  |                                                                                                                                                                                | 10c. City, Town or Location<br><b>Dundalk</b>              |                                                                                                                                                    | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                 |  |
| 10e. Street and Number<br><b>63 Wise Avenue</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         | 10f. Zip Code<br><b>21222</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                                                                 |                                                  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 Years</b><br>College (1-4or 5+) -----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Painter</b>                                                                                                     |                                                  | 16b. Kind of Business/Industry<br><b>Painting Contractor</b>                                                                                                                   |                                                            | 17. Father's Name (First, Middle, Last)<br><b>Hal Leishure</b>                                                                                     |                                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Bunch</b>                                                                                                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol L. Leishure (Wife)</b>                                                                                                                                                                                                                                                                                                                                          |                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>63 Wise Ave. Dundalk, Maryland 21222</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>                                                                      |                                                            | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>                                                                                |                                                                                                | 21. Signature of Funeral Service Licensee<br><b>J. Wayne Osterling</b>                                                                                                                          |  |
| 22. Name and Address of Facility<br><b>Bradley-Ashton-Matthews Funeral Home, Inc.<br/>2134 Willow Spring Rd. Dundalk, MD 21222</b>                                                                                                                                                                                                                                                                                           |                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic rectal cancer</b><br>Due to (or as a consequence of):<br><b>Bowel obs. trachosis</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Metastatic rectal cancer</b><br>Due to (or as a consequence of):<br><b>Bowel obs. trachosis</b><br>Due to (or as a consequence of): |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                           |                                                  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                          |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                               |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |                                                                                         | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 28a. Date of Injury (Month, Day Year)<br><b>NA</b>                                                                                                                                                                                    |                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                        |                                                                                                | 28d. Describe how injury occurred<br><b>NA</b>                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                         | 29b. Signature and title of certifier<br><b>B. Pharoan, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 29c. License number<br><b>D0019637</b>                                                                                                                                                                                                |                                                  | 29d. Date signed (Month, Day, Year)<br><b>7/24/00</b>                                                                                                                          |                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>B. PHAROAN, MD PO Box 452 Timonium MD 21094</b>         |                                                                                                | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                         |  |
| 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         | 33. State Registrar<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 34. State Registrar<br><b>[Signature]</b>                                                                                                                                                                                             |                                                  | 35. State Registrar<br><b>[Signature]</b>                                                                                                                                      |                                                            | 36. State Registrar<br><b>[Signature]</b>                                                                                                          |                                                                                                | 37. State Registrar<br><b>[Signature]</b>                                                                                                                                                       |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 23360

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                         |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   |                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><u>Lichtel</u>                                                              |                                                                                                                                                                                  | 2. Date of Death<br>Month <u>July</u> Day <u>21</u> Year <u>2000</u>                                                                        |                                                                                                                                                   | 3. Time of Death<br><u>6:20pm</u>                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><u>Johns Hopkins Bayview Medical Center Baltimore</u> |                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>                                                                                    |                                                                                                                                                   | 4c. County of Death                                                                                                   |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><u>215-30-1923</u>                                                                         | 6. Sex<br><u>1</u> M <u>2</u> F                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><u>72</u> Yrs.                                                                                            | 8. Date of Birth (Month, Day, Year)<br><u>2/17/1928</u>                                                                                           | 9. Birthplace (State or Foreign Country)<br><u>Scotland</u>                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                             |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   |                                                                                                                       |
| 10a. State<br><u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                         | 10b. County<br><u>Baltimore</u>                                                                                                                                                  |                                                                                                                                             | 10c. City, Town or Location<br><u>Dundalk</u>                                                                                                     |                                                                                                                       |
| 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   |                                                                                                                       |
| 10e. Street and Number<br><u>6811 Dunhill Road</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                         |                                                                                                                                                                                  | 10f. Zip Code<br><u>21222</u>                                                                                                               |                                                                                                                                                   | 10g. Citizen of What Country?<br><u>Scotland</u>                                                                      |
| 11. Marital Status<br><u>1</u> Never Married <u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates:                                                                           |                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify: |                                                                                                                       |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                         |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   |                                                                                                                       |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                         |                                                                                                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Homemaker</u>               |                                                                                                                                                   | 16b. Kind of Business/Industry<br><u>Own Home</u>                                                                     |
| 17. Father's Name (First, Middle, Last)<br><u>Daniel Hodkinson</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                         |                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Isabella Stewart</u>                                                                |                                                                                                                                                   |                                                                                                                       |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Taryn Lichtel Daughter</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                         |                                                                                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>6811 Dunhill Road, Dundalk MD 21222</u> |                                                                                                                                                   |                                                                                                                       |
| 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Chesapeake Crematory</u>                                                                            |                                                                                                                                             | 20c. Location - City or Town, State<br><u>7/25 Beltsville, Maryland</u>                                                                           |                                                                                                                       |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                         |                                                                                                                                                                                  | 22. Name and Address of Facility<br><u>Bradley Ashton Matthews Funeral Home, Inc.</u><br><u>2134 Willow Spring Road, Dundalk MD 21222</u>   |                                                                                                                                                   |                                                                                                                       |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. METABOLIC ACIDOSIS</u><br>Due to (or as a consequence of):<br><u>b. SEPSIS</u><br>Due to (or as a consequence of):<br><u>c.</u><br>Due to (or as a consequence of):<br><u>d.</u><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                         |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   | Approximate Interval Between Onset and Death<br><u>2 Hours</u><br><u>1 DAY</u>                                        |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic Pulmonary Embolus</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                         |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   | 23b. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown |
| 24a. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                         |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> No               |
| 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) |                                                                                                                                             |                                                                                                                                                   |                                                                                                                       |
| 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide <u>4</u> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                                                           |                                                                                                                                             | 28b. Time of Injury<br><u>M</u>                                                                                                                   |                                                                                                                       |
| 28c. Injury at Work?<br><u>1</u> Yes <u>2</u> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                         | 28d. Describe how injury occurred                                                                                                                                                |                                                                                                                                             | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                                                                                       |
| 29a. Certifier (Check only one)<br><u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                            |                                                                                                                         |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   |                                                                                                                       |
| 29b. Signature and title of certifier<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                         | 29c. License number<br><u>D51185</u>                                                                                                                                             |                                                                                                                                             | 29d. Date signed (Month, Day, Year)<br><u>July 21, 2000</u>                                                                                       |                                                                                                                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>COLLEEN CHRISTMAS, MD 5505 Hopkins Bayview Circle Baltimore, Maryland 21224</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                         |                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   |                                                                                                                       |
| 31. Date filed (Month, Day, Year)<br><u>JUL 25 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                         | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                                                  |                                                                                                                                             |                                                                                                                                                   |                                                                                                                       |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.



ADH  
GARY LEWIS, SR.  
00-3968-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23361

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>GARY M. LEWIS, SR</b>                         |                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>JULY</b> Day <b>18</b> Year <b>2000</b> |                                                                                                                                                    | 3. Time of Death<br><b>1605 PM</b>                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>1719 E. 33RD STREET</b> |                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>        |                                                                                                                                                    | 4c. County of Death<br><b>N/A</b>                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>217-40-2250</b>                                              |                                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.                     |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>01-25-45</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                        |                                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                              | 10b. County<br><b>N/A</b>                                            |                                                                                                                                                    | 10c. City, Town or Location<br><b>BALTIMORE</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              | 10e. Street and Number<br><b>400 MILLINGTON AVENUE</b>                                                                                                                                                                                                                                                      |                                                                            | 10f. Zip Code<br><b>21223</b>                                                                                                                                                                |                                                                      | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                        |                                                        |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                            |                                                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b><br>College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LONG SHOREMAN</b>                                                                                                                                                                           |                                                                            | 16b. Kind of Business/Industry<br><b>SHIPPING</b>                                                                                                                                            |                                                                      |                                                                                                                                                    |                                                        |  |
| 17. Father's Name (First, Middle, Last)<br><b>EDWARD LEWIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY WILLIAMS</b>                                                                                                                    |                                                                      |                                                                                                                                                    |                                                        |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLENE LEWIS   WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>400 MILLINGTON AVE, BALTO. MD. 21223</b>                                                 |                                                                      |                                                                                                                                                    |                                                        |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>                                                                                                                                                                                                         |                                                                            | 20c. Location - City or Town, State<br><b>07-22-00 RANOALSTOWN, MD</b>                                                                                                                       |                                                                      |                                                                                                                                                    |                                                        |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              | 22. Name and Address of Facility<br><b>VAUGHN C. GREENE FUNERAL SERVICE<br/>5151 BALTO NATL AVE, BALTO. MD. 21229</b>                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                        |  |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>INTRACRANIAL HEMORRHAGE</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                 |                                                                            | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                        |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                        |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                        |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                        |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                      |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                        |                                                        |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                      |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                      |                                                                                                                                                    |                                                        |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                               |                                                                                              | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>OCME</b>                                                                                                                                                           |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>JULY 19, 2000</b>                                                                                        |                                                        |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARYANN D. KOBOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                        |  |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                        |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23362

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------|--|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br>Virginia M. Moeller                                    |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 22, 2000 |                                                                                                                                                                                                  |                                                   |                                                                                                    | 3. Time of Death<br>3:30 am                                      |                                                |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br>Greater Baltimore Medical Center |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Towson      |                                                                                                                                                                                                  |                                                   |                                                                                                    | 4c. County of Death<br>Baltimore                                 |                                                |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br>212-24-8332                                                           |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>86                |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br>12-12-1913 |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland             |                                                |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Usual Residence of Decedent                                                                        |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    | 10b. County<br>Baltimore |                                                                                                                                                       | 10c. City, Town or Location<br>Towson                                                                                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                  |                                                   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                  |                                                |  |  |
| 10e. Street and Number<br>1307 Westellen Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                    |                          |                                                                                                                                                       | 10f. Zip Code<br>21286                                                                                                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                  |                                                   | 10g. Citizen of What Country?<br>U. S. A.                                                          |                                                                  |                                                |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         |                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                   |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                          |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Department Manager                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                   | 16b. Kind of Business/Industry<br>Hutzler's                                                        |                                                                  |                                                |  |  |
| 17. Father's Name (First, Middle, Last)<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                    |                          |                                                                                                                                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br>UNKNOWN                                                                                                                                                                                                                                            |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs Ruth A. Fowble (Friend)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                          |                                                                                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1127 Longbrook Road, Lutherville, Maryland 21093                                                                                                                                                       |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                          |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Mem. Gards.                                                                                                                                                                                                    |                                                     |                                                                                                                                                                                                  |                                                   | 20c. Location - City or Town, State<br>7-25-00 Timonium, Maryland                                  |                                                                  |                                                |  |  |
| 21. Signature of Funeral Service Licensee<br>Wallace S. Brooks, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                          |                                                                                                                                                       | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Road, Towson, Md. 21204                                                                                                                                                                                                 |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <i>atherosclerotic heart disease</i><br/>Due to (or as a consequence of):</p> <p>b. <i>chronic obstructive lung disease</i><br/>Due to (or as a consequence of):</p> <p>c. <i>emphysema, multiple causes</i><br/>Due to (or as a consequence of):</p> <p>d.</p> </div> <div> <p>Approximate Interval Between Onset and Death<br/>3 weeks</p> </div> </div> |                                                                                                    |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                    |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                    |                          |                                                                                                                                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |                          |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    |                          |                                                                                                                                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                     | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                                  | 28d. Describe how injury occurred              |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                    |                          |                                                                                                                                                       | 29b. Signature and title of certifier<br>E. Hutzler Wilson M.D.                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                   | 29c. License number<br>D12487                                                                      |                                                                  | 29d. Date signed (Month, Day, Year)<br>7-22-00 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>E. Hutzler Wilson M.D. - Suite 203, E. Parkview, GARC, Baltimore, 21204                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                    |                          |                                                                                                                                                       | 32. Registrar's Signature<br>James B. Sparks                                                                                                                                                                                                                                                            |                                                     |                                                                                                                                                                                                  |                                                   |                                                                                                    |                                                                  |                                                |  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 23363

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                             |                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                        |                                                                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Charles J. Matczuk, Sr.         |                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br>July 24 2000 |                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                                                                                                                                                                                                                                           | 3. Time of Death<br>12 05 A            |                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>Levindale |                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br>Baltimore  |                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                                                                                                                                                                                                                                           | 4c. County of Death                    |                                                                                                                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>216-09-8621                                    |                                                                                                                                                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br>83 Yrs.          |                                                                                                                                                                                                                                                                         | If Under 1 Year<br>Months Days |                                                                                                                                                                                                                                                                                                                                                                                                                           | If Under 24 Hrs.<br>Hours Min.         |                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br>January 28, 1917                     |                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br>MD.                            |                                                                                                                                                                                                                                                                                             | 10a. State<br>MD.                                  |                                                                                                                                                                                                                                                                         | 10b. County<br>Baltimore       |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10c. City, Town or Location<br>Glencoe |                                                                                                                      |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                          |                                                                            | 10e. Street and Number<br>930 Upper Glencoe Rd.                                                                                                                                                                                                                                             |                                                    | 10f. Zip Code<br>21152                                                                                                                                                                                                                                                  |                                | 10g. Citizen of What Country?<br>USA                                                                                                                                                                                                                                                                                                                                                                                      |                                        |                                                                                                                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                                                                                        |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                                                                                                                                                                                                                                                                                                    |                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Painter |  |
| 16b. Kind of Business/Industry<br>Union                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                             | 17. Father's Name (First, Middle, Last)<br>Theodore Matczuk                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Victoria Wojkiewicz                                                                                                                                                                                                                    |                                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Edward J. Matczuk (son)                                                                                                                                                                                             |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>932 Upper Glencoe Rd. Glencoe, MD. 21152                                                                                                                                                                                                                                                                                 |                                        |                                                                                                                      |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holy Rosary Cemetery                                                          |                                                                            | 20c. Location - City or Town, State<br>Baltimore, MD.                                                                                                                                                                                                                                       |                                                    | 21. Signature of Funeral Service Licensee<br>Dennis C. Carroll                                                                                                                                                                                                          |                                | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, MD. 21204                                                                                                                                                                                                                                                                                                                     |                                        |                                                                                                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Respiratory Failure<br>Due to (or as a consequence of):<br>Abdominal Aortic Aneurysm<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                             | Approximate Interval Between Onset and Death<br>years                                                                                                   |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                    |                                                    | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                               |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                    |                                        |                                                                                                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                             | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                    | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                    |                                        | 28b. Time of Injury<br>M                                                                                             |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                             | 28d. Describe how injury occurred                                                                                                                       |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                            |                                | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                        |                                                                                                                      |  |
| 29b. Signature and title of certifier<br>Debra S. Werthemer MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                             | 29c. License number<br>D23767                                                                                                                           |                                                                            | 29d. Date signed (Month, Day, Year)<br>July 24, 2000                                                                                                                                                                                                                                        |                                                    | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Debra S. Werthemer MD, 2434 W. Belvedere Ave, Balto, MD 21215                                                                                                                   |                                | 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                          |                                        | 32. Registrar's Signature<br>Janey B. Sparks                                                                         |  |

ORIGINAL

10

1

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23364

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

Charles Marinella

2. Date of Death

Month 7 Day 22 Year 2000

3. Time of Death

8:50 a.m.

4a. Facility Name (If not Institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

276-10-6974

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 30, 1915

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4406 Furley Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WWII  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Electronics

17. Father's Name (First, Middle, Last)

James Marinella

18. Mother's Name (First, Middle, Maiden Surname)

Anna DiRocco

19a. Informant's Name/Relationship (Type, Print)

Mr. Michael Marinella- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 60424 Fort Myers, Florida 33906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sacred Heart of Jesus

Date

7-27-00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. coronary artery disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus, bradycardia, atrial fibrillation

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michele F. Bellantoni MD

29c. License number

D33316

29d. Date signed (Month, Day, Year)

7-22-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

michele F. Bellantoni MD 5505 Hopkins Bayview Circle Baltimore MD 21229

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23365

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

WILBUR CHESTER MORRIS

2. Date of Death

Month

Day

Year

JULY

11 2000

3. Time of Death

2015

4a. Facility Name (If not institution, give street and number)

3706 35th Street

4b. City, Town, or Location of Death

MT. RANIER

4c. County of Death

PRINCE GEORGES

5. Social Security Number

355-24-8545

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8-19-32

9. Birthplace (State or Foreign Country)

CHICAGO, ILL.

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

MT. RANIER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3706 35th Street

10f. Zip Code

20712

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: BLACK15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

LAB TECHNICIAN

16b. Kind of Business/Industry

MEDICAL

17. Father's Name (First, Middle, Last)

CHARLES WILLIAM MORRIS SR.

18. Mother's Name (First, Middle, Maiden Surname)

JOERINE BROWN

19a. Informant's Name/Relationship (Type, Print)

JOERINE M. BURRELL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7612 S. Martin Luther King Dr. Chicago, Ill

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MOUNT OLIVET CEMETERY 7-26-00 CHICAGO, ILL

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HOWELL FUNERAL HOME

4600 LIBERTY HGHTS AVE, BALTO. MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. LUNG CANCER WITH METASTASIS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

JULY 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALVADOR SYLVESTER, 3001 HOSPITAL DR, CHEVERLY, MARYLAND 20785

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23366

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Alfred G. Matthews

2. Date of Death

July

23,

2000

3. Time of Death

2:45pm

4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric Rehab. Center

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

5. Social Security Number

688-65-5432

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 21, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

BALTIMORE

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1315 Chesaco Ave. #201

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager Accounting Payroll

16b. Kind of Business/Industry

Shaw-Walker

17. Father's Name (First, Middle, Last)

James Matthews

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Wagner

19a. Informant's Name/Relationship (Type, Print)

George E. Matthews - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1315 Chesaco Ave #201, Rosedale MD 21237

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evens Funeral Chapel - Baltimore, P.A.

Date

July 24,

20c. Location - City or Town, State

22000 Forest Hill, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Evens Funeral Chapel, Inc. 2325 York Road, Timonium MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Temporo - Parietal CVA

Approximate Interval Between Onset and Death

2 wks

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, Parkinson's disease

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

July 24, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MALIKA WASSEM, 709 EASTERN BLVD, MD - 21221.

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



My dear Mr. [Name]  
I have just received your letter of the 10th inst. and am  
glad to hear that you are well and happy.

I am very busy at present, but I will  
write you again as soon as I have time.

I am, dear Mr. [Name], very truly  
yours,  
[Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23367

Amended item 23a per md g785 7-27-00wj

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                   |                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><u>Bertha Morrison</u>                                              |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <u>July</u> Day <u>21</u> Year <u>2000</u> |                                                                                                                                                   | 3. Time of Death<br><u>5:36 pm</u>         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><u>University of Maryland Medical Systems</u> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><u>Baltimore</u>             |                                                                                                                                                   | 4c. County of Death<br><u>NA</u>           |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><u>217-24-4480</u>                                                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><u>85</u> Yrs.                     | If Under 1 Year<br>Months _____ Days _____                                                                                                        | If Under 24 Hrs.<br>Hours _____ Min. _____ |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><u>6-5-15</u>                                                            |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><u>Virginia</u>          |                                                                                                                                                   |                                            |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                   |                                            |
| 10a. State<br><u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 | 10b. County<br><u>N/A</u>                                                                                                                                                                                                                                                                   |                                                                      | 10c. City, Town or Location<br><u>Baltimore</u>                                                                                                   |                                            |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                                                 | 10e. Street and Number<br><u>1426 Ward Street</u>                                                                                                                                                                                                                                           |                                                                      | 10f. Zip Code<br><u>21230</u>                                                                                                                     |                                            |
| 10g. Citizen of What Country?<br><u>USA</u>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 | 11. Mental Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                               |                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                            |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |                                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                                                                                                                                                                                                                     |                                                                      | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6th</u> College (1-4or 5+) <u>N/A</u>           |                                            |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Domestic</u>                                                                                                                                                                                                                                                                                              |                                                                                                                 | 16b. Kind of Business/Industry<br><u>Private Duty</u>                                                                                                                                                                                                                                       |                                                                      | 17. Father's Name (First, Middle, Last)<br><u>John Barksdale</u>                                                                                  |                                            |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><u>unknown</u>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                 | 19e. Informant's Name/Relationship (Type, Print)<br><u>James Morrison / son</u>                                                                                                                                                                                                             |                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1808 Carroll Street, Baltimore, MD, 21230</u> |                                            |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Maryland National Cemetery</u>                                                                                                                                                                                 |                                                                      | 20c. Location - City or Town, State<br><u>Landover, MD</u>                                                                                        |                                            |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 | 22. Name and Address of Facility<br><u>Wyllie Funeral Home, P.A.<br/>1638 N. Gilmer Street Balto, MD 21217</u>                                                                                                                                                                              |                                                                      |                                                                                                                                                   |                                            |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                   |                                            |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 | a. <u>Asystole</u><br>Due to (or as a consequence of):                                                                                                                                                                                                                                      |                                                                      |                                                                                                                                                   |                                            |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                |                                                                                                                 | b. <u>Aspiration</u> Aspiration Pneumonia<br>Due to (or as a consequence of):                                                                                                                                                                                                               |                                                                      |                                                                                                                                                   |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 | c. _____<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                |                                                                      |                                                                                                                                                   |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 | d. _____<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                |                                                                      |                                                                                                                                                   |                                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Atrial Fibrillation</u><br><u>Congestive Heart Failure</u>                                                                                                                                                                                                                                   |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                   |                                            |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                   |                                            |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                      |                                                                                                                                                   |                                            |
| 25. Was case referred to medicot examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                      |                                                                                                                                                   |                                            |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                                                                 | 28a. Date of Injury (Month, Day, Year)<br>_____                                                                                                                                                                                                                                             |                                                                      | 28b. Time of Injury<br>M _____                                                                                                                    |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |                                                                      | 28d. Describe how injury occurred                                                                                                                 |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                            |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                   |                                            |
| 29b. Signature and title of certifier<br><u>Joyce A. Dietrich MD</u>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                 | 29c. License number<br><u>P11415</u>                                                                                                                                                                                                                                                        |                                                                      | 29d. Date signed (Month, Day, Year)<br><u>July 24/2000</u>                                                                                        |                                            |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>Joyce Dietrich MD 22 South Greene St, Baltimore, Maryland 21201</u>                                                                                                                                                                                                                                                            |                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                   |                                            |
| 31. Date filed (Month, Day, Year)<br><u>JUL 24 2000</u>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                 | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                   |                                            |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23368

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Khadeeya Fatou Mata</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>2000</b>                                                                                                                                                                                                                        |                                                                             | 3. Time of Death<br><b>1:48 PM</b>                                                                                                                                                            |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>2201 Walbrook Ave #203</b>                                                                                                                                                                                                                                                                                                                                      |                                                                            | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                                                                                                                    |                                                                             | 4c. County of Death<br><b>NA</b>                                                                                                                                                              |  |
| 5. Social Security Number<br><b>215-248427</b>                                                                                                                                                                                                                                                                                                                                                                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs., last birthday)<br><b>78</b> Yrs.                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>April 3, 1922</b>                 | 9. Birthplace (State or Foreign)<br><b>MARYLAND</b>                                                                                                                                           |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                              | 10b. County<br><b>NA</b>                                                   | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                                                                                                                             |                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                |  |
| 10a. Street and Number<br><b>2201 WALBROOK AVE #203</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 10f. Zip Code<br><b>21216</b>                                                                                                                                                                                                                                                               |                                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                       |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>                                                                                                                                                      |                                                                             |                                                                                                                                                                                               |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Geriatrician</b>                                                                                                                                                                                                                                                                                                     |                                                                            | 16b. Kind of Business/Industry<br><b>Geriatrics</b>                                                                                                                                                                                                                                         |                                                                             |                                                                                                                                                                                               |  |
| 17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Vernice Downing</b> |                                                                                                                                                                                               |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Claudia K. McKee / daughter</b>                                                                                                                                                                                                                                                                                                                                               |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1823 Fayette St. Baltimore, MD, 21223</b>                                                                                                                                               |                                                                             |                                                                                                                                                                                               |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Louder Park Cemetery 07-27-00 BALTIMORE, MD</b>                                                                                                                                                                |                                                                             | 20c. Location - City or Town, State                                                                                                                                                           |  |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 22. Name and Address of Facility<br><b>WYLIE FUNERAL HOME P.A.<br/>638 N. Gilmore Street Balto, MD 21217</b>                                                                                                                                                                                |                                                                             |                                                                                                                                                                                               |  |
| Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | a. <b>Chronic obstructive airway disease</b> years                                                                                                                                                                                                                                          |                                                                             |                                                                                                                                                                                               |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | b. <b>Hypertension</b>                                                                                                                                                                                                                                                                      |                                                                             |                                                                                                                                                                                               |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | c.                                                                                                                                                                                                                                                                                          |                                                                             |                                                                                                                                                                                               |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | d.                                                                                                                                                                                                                                                                                          |                                                                             |                                                                                                                                                                                               |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                             |                                                                                                                                                                                               |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                    |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                             |                                                                                                                                                                                               |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                           |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                             | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                             |                                                                                                                                                                                               |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                               |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                             |                                                                                                                                                                                               |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |
| 29b. Signature and title of certifier<br><b>Amatun M. Naeem MD</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>D 15503</b>                                                                                                                                                                                                                                                       |                                                                             | 29d. Date signed (Month, Day, Year)<br><b>July 20, 2000</b>                                                                                                                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AMATUN M. NAEEM, 501 Dolphin St Balto MD 21217</b>                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                             |                                                                                                                                                                                               |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G785

1-26-00, WR

Certificate of Death

Reg. No.

00 23369

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |  |                                                                            |                                                                                                                                                                                                                                                                                             |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>Gregory M. Moore</b>                             |  |                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>July 23 2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>5:33 P.M.</b>                                                           |                                                                                             |                                                                                                                                                    |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not Institution, give street and number)<br><b>Johns Hopkins Hospital</b> |  |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                                                                                                                                                              | 4c. County of Death<br><b>N/A</b>                                                              |                                                                                             |                                                                                                                                                    |                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>212-56-6977</b>                                                 |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.          |                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>December 20, 1959</b>                                |                                                                                             |                                                                                                                                                    |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD</b>                                                                         |  | 10b. County<br><b>NA</b>                                                   |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Baltimore</b>           |                                                                                                                                                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                             |                                                                                                                                                    |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                        |                                                                                                 |  |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b>          |                                                                                                                                                    |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14-16) <b>2</b>                                                                                                                                                                                                                                                                                                     |                                                                                                 |  |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Waiter</b>                                                                                                                                                                  |                                                           | 16b. Kind of Business/Industry<br><b>Food Service</b>                                                                                                                                        |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry L. Moore</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |  |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carolyn Carwile</b>                                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn Carwile</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |  |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1231 Etting St., Baltimore, MD, 21217</b>                                                                                                                                               |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                 |                                                                                                 |  |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                                                                                                                                                            |                                                           | 20c. Location - City or Town, State<br><b>Catonsville, MD</b>                                                                                                                                |                                                                                                | 20d. Date<br><b>7/05/00</b>                                                                 |                                                                                                                                                    |                                   |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |  |                                                                            | 22. Name and Address of Facility<br><b>Wyle Funeral Home Baltimore, MD 21217</b><br><b>638 N. Gilmer St.</b>                                                                                                                                                                                |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>ACQUIRED IMMUNODEFICIENCY SYNDROME</b><br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |                                                                                                 |  |                                                                            | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                           |                                                                                                 |  |                                                                            | 24a. Was an autopsy performed?<br><b>Inspection</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                  |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                 |  |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                            |                                                                                                 |  |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                           | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                    | 28d. Describe how injury occurred |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.          |                                                                                                 |  |                                                                            | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                           | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                       |                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>July 24, 2000</b>                                 |                                                                                                                                                    |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Pestaner, M.D.</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                 |  |                                                                            | <b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                           |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 27 2000</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |  |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                           |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                    |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G785-26-00 WR

Certificate of Death

Reg. No.

00 23370

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Isaac W. Manuel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  | 2. Date of Death<br>Month: <b>JULY</b> Day: <b>21</b> Year: <b>2000</b>                                                                                                                      |                                                                                                | 3. Time of Death<br><b>15:39 PM</b>                                                         |                                                       |                                                     |
|                                                                      | 4a. Facility Name (If not institution, give street and number)<br><b>1523 MONTEPELIER STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                     |                                                                                                | 4c. County of Death<br><b>N/A</b>                                                           |                                                       |                                                     |
| Funeral<br>Director                                                  | 5. Social Security Number<br><b>220-64-9855</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.                                                                                                                                                                                                                                                         | If Under 1 Year<br>Months: Days: | If Under 24 Hrs.<br>Hours: Min.                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 19 1955</b>                                    |                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |                                                     |
|                                                                      | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10b. County<br><b>N/A</b>                                                  | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                             |                                                       |                                                     |
|                                                                      | 10e. Street and Number<br><b>125 N. Broadway St</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  | 10f. Zip Code<br><b>21231</b>                                                                                                                                                                |                                                                                                | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                       |                                                     |
|                                                                      | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                        |                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |                                                       |                                                     |
|                                                                      | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <b>9th</b> College (1-4 or 5+):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction</b>                                                                                                                                                                         |                                  | 16b. Kind of Business/Industry<br><b>Builder</b>                                                                                                                                             |                                                                                                |                                                                                             |                                                       |                                                     |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>Isaac Wallace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alma Manuel</b>                                                                                                                      |                                                                                                |                                                                                             |                                                       |                                                     |
|                                                                      | 19a. Informant's Name/Relationship (Type, Print)<br><b>Claylette Manuel / sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>125 N. Broadway St. Baltimore, MD 21231</b>                                              |                                                                                                |                                                                                             |                                                       |                                                     |
|                                                                      | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus</b>                                                                                                                                                                                                                 |                                  | Date                                                                                                                                                                                         |                                                                                                | 20c. Location - City or Town, State<br><b>Arbutus, MD</b>                                   |                                                       |                                                     |
|                                                                      | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 22. Name and Address of Facility<br><b>Gary P. March Funeral Home P.A.<br/>270 Fredhilton Biss Baltimore, MD 21229</b>                                                                                                                                                                                   |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>NARCOTIC INTOXICATION</b>                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             | Approximate Interval Between Onset and Death          |                                                     |
|                                                                      | <div style="display: flex;"> <div style="flex: 1;">                 a. Due to (or as a consequence of):<br/><br/>                 b. Due to (or as a consequence of):<br/><br/>                 c. Due to (or as a consequence of):<br/><br/>                 d. Due to (or as a consequence of):             </div> <div style="flex: 1; font-size: 4em; margin: 0 10px;">}</div> <div style="flex: 1;">                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </div> </div> |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
|                                                                      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
|                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                       |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
|                                                                      | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
|                                                                      | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                        |                                                                            | 28a. Date of Injury (Month, Day, Year)<br><b>7-21-00</b>                                                                                                                                                                                                                                                 |                                  | 28b. Time of Injury<br><b>UNKNOWN</b>                                                                                                                                                        |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                       | 28d. Describe how injury occurred<br><b>UNKNOWN</b> |
|                                                                      | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND: HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1523 MONTEPELIER ST. BALTIMORE CITY, MD</b>                                                                                                                                                                           |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
| State Registrar                                                      | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
|                                                                      | 29b. Signature and title of certifier<br><b>[Signature] M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                   |                                  | 29d. Date signed (Month, Day, Year)<br><b>JULY 22, 2000</b>                                                                                                                                  |                                                                                                |                                                                                             |                                                       |                                                     |
|                                                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |
| State Registrar                                                      | 31. Date filed (Month, Day, Year)<br><b>JUL 27 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                       |                                                     |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0055.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene 00 23371

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                                                                 |                                           |                                                                                             |                                                                                                                                                                                                  |                                                                 |                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><u>George A. Meyers, Jr</u>                        |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               | 2. Date of Death<br>Month <u>7</u> Day <u>21</u> Year <u>2000</u>                                                                                                                               |                                           |                                                                                             | 3. Time of Death<br><u>7:00pm</u>                                                                                                                                                                |                                                                 |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><u>Joseph Richey Hospice</u> |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               | 4b. City, Town, or Location of Death<br><u>Baltimore, MD</u>                                                                                                                                    |                                           |                                                                                             | 4c. County of Death<br><u>Baltimore City</u>                                                                                                                                                     |                                                                 |                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><u>220-03-2975</u>                                                |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                 |                                                                                                                               | 7. Age (In yrs. last birthday)<br><u>81</u> Yrs.                                                                                                                                                |                                           | 8. Date of Birth (Month, Day, Year)<br><u>10/20/18</u>                                      |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>     |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                    |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               | 10c. City, Town or Location<br><u>Arbutus</u>                                                                                                                                                   |                                           |                                                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                                 |                                                |  |
| 10a. State<br><u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                | 10b. County<br><u>Baltimore</u> |                                                                                                                                                                                                                                                                                                            | 10e. Street and Number<br><u>1258 Linden Ave.</u>                                                                             |                                                                                                                                                                                                 |                                           |                                                                                             | 10f. Zip Code<br><u>21227</u>                                                                                                                                                                    |                                                                 | 10g. Citizen of What Country?<br><u>U.S.A.</u> |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                          |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                           |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                                                                                                                          |                                                                 |                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Machinist</u> |                                                                                                                                                                                                 |                                           |                                                                                             | 16b. Kind of Business/Industry<br><u>Kaiser Industrial</u>                                                                                                                                       |                                                                 |                                                |  |
| 17. Father's Name (First, Middle, Last)<br><u>George A. Meyers, Sr.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Elizabeth Schabhut</u>                                                                                                                  |                                           |                                                                                             |                                                                                                                                                                                                  |                                                                 |                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Cathy Johnson, daughter</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1213 Brandford Rd. Catonsville, MD. 21228</u>                                               |                                           |                                                                                             |                                                                                                                                                                                                  |                                                                 |                                                |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metro Crematory</u>                                                                                                                                                                                                           |                                                                                                                               |                                                                                                                                                                                                 | Data<br><u>7-24-00</u>                    |                                                                                             | 20c. Location - City or Town, State<br><u>Catonsville, MD</u>                                                                                                                                    |                                                                 |                                                |  |
| 21. Signature of Funeral Service Licensee<br><u>Sean A. Lubeck</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               | 22. Name and Address of Facility<br><u>Ambrose Funeral Home, Inc.<br/>1328 Sulphur Spring Rd. Arbutus, MD. 21227</u>                                                                            |                                           |                                                                                             |                                                                                                                                                                                                  |                                                                 |                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. Congestive heart failure</u><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                                                                 |                                           |                                                                                             |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br><u>15 years</u> |                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                                                                 |                                           |                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                 |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                                                                 |                                           |                                                                                             | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                 |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                                                                 |                                           |                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |                                                                 |                                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                |                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>Hospice</u> |                                                                                                                               |                                                                                                                                                                                                 |                                           |                                                                                             |                                                                                                                                                                                                  |                                                                 |                                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                |                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                                                                                                               | 28b. Time of Injury<br><u>M</u>                                                                                                                                                                 |                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  | 28d. Describe how injury occurred                               |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |                                                                                                                               |                                                                                                                                                                                                 |                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                                                                                                                                                  |                                                                 |                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                  |                                                                                                |                                 | 29b. Signature and title of certifier<br><u>Tim Polk MD</u>                                                                                                                                                                                                                                                |                                                                                                                               |                                                                                                                                                                                                 | 29c. License number<br><u>D51788 (MD)</u> |                                                                                             | 29d. Date signed (Month, Day, Year)<br><u>7/22/00</u>                                                                                                                                            |                                                                 |                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Timothy D. Polk, MD 620 Bolton St. Bel Air, MD 21014</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                                                                 |                                           |                                                                                             |                                                                                                                                                                                                  |                                                                 |                                                |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 25 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                |                                 | 32. Registrar's Signature<br><u>Benjamin S. Sparks</u>                                                                                                                                                                                                                                                     |                                                                                                                               |                                                                                                                                                                                                 |                                           |                                                                                             |                                                                                                                                                                                                  |                                                                 |                                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 23372

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Zipporah Newson                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |                                 | 2. Date of Death<br>Month Day Year<br>July 24, 2000                                                                                                                                               |                                                                                                                                             |                                                                                      |                                                                  | 3. Time of Death<br>7:50 A.M.                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>3400 Lotsford Vista Road                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |                                 | 4b. City, Town, or Location of Death<br>Mitchellville                                                                                                                                             |                                                                                                                                             |                                                                                      |                                                                  | 4c. County of Death<br>Prince Georges                                                            |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>439-36-7458                                                                                                                                                                                                                                                                |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |                                 | 7. Age (In yrs. last birthday)<br>76 Yrs.                                                                                                                                                         |                                                                                                                                             | 8. Date of Birth (Month, Day, Year)<br>March 10, 1924                                |                                                                  | 9. Birthplace (State or Foreign Country)<br>Louisiana                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                  |  | 10b. County<br>Prince Georges                                                                                                                                                                                                                                                                           |                                 | 10c. City, Town or Location<br>Mitchellville                                                                                                                                                      |                                                                                                                                             |                                                                                      |                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>3400 Lotsford Vista Road                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                 | 10f. Zip Code<br>20721                                                                                                                                                                            |                                                                                                                                             | 10g. Citizen of What Country?<br>United States                                       |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                             |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th grade<br>College (1-4 or 5+) College (1-4 or 5+)                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cafeteria Employee                                                                   |                                                                                                                                             |                                                                                      | 16b. Kind of Business/Industry<br>Food Service                   |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Silas Turner                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br>unavailable                                                                                                                                  |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br>John Newson                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2103 Crimson Lane Bloomington, Illinois 61704                                                    |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                         |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Saint Paul Cemetery                                                                                                                                                                                                           |                                 | 20c. Location - City or Town, State<br>Rayville Louisiana                                                                                                                                         |                                                                                                                                             | 20d. Date<br>7/29/00                                                                 |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                 | 22. Name and Address of Facility<br>Latney's Funeral Home 3831 Georgia Avenue, N. W. Washington, D. C. 20011                                                                                      |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Metastatic Colon Cancer |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23b. Approximate Interval Between Onset and Death<br>18 months                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                      |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                  |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                 | 28b. Time of Injury<br>M                                                                                                                                                                          |                                                                                                                                             | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         | 29c. License number<br>DC 19757 |                                                                                                                                                                                                   |                                                                                                                                             | 29d. Date signed (Month, Day, Year)<br>7/24/00                                       |                                                                  |                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael Hawkins, MD 110 Irving Street, N.W. Washington, D.C. 20010                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                 |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         | 32. Registrar's Signature<br>   |                                                                                                                                                                                                   |                                                                                                                                             |                                                                                      |                                                                  |                                                                                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

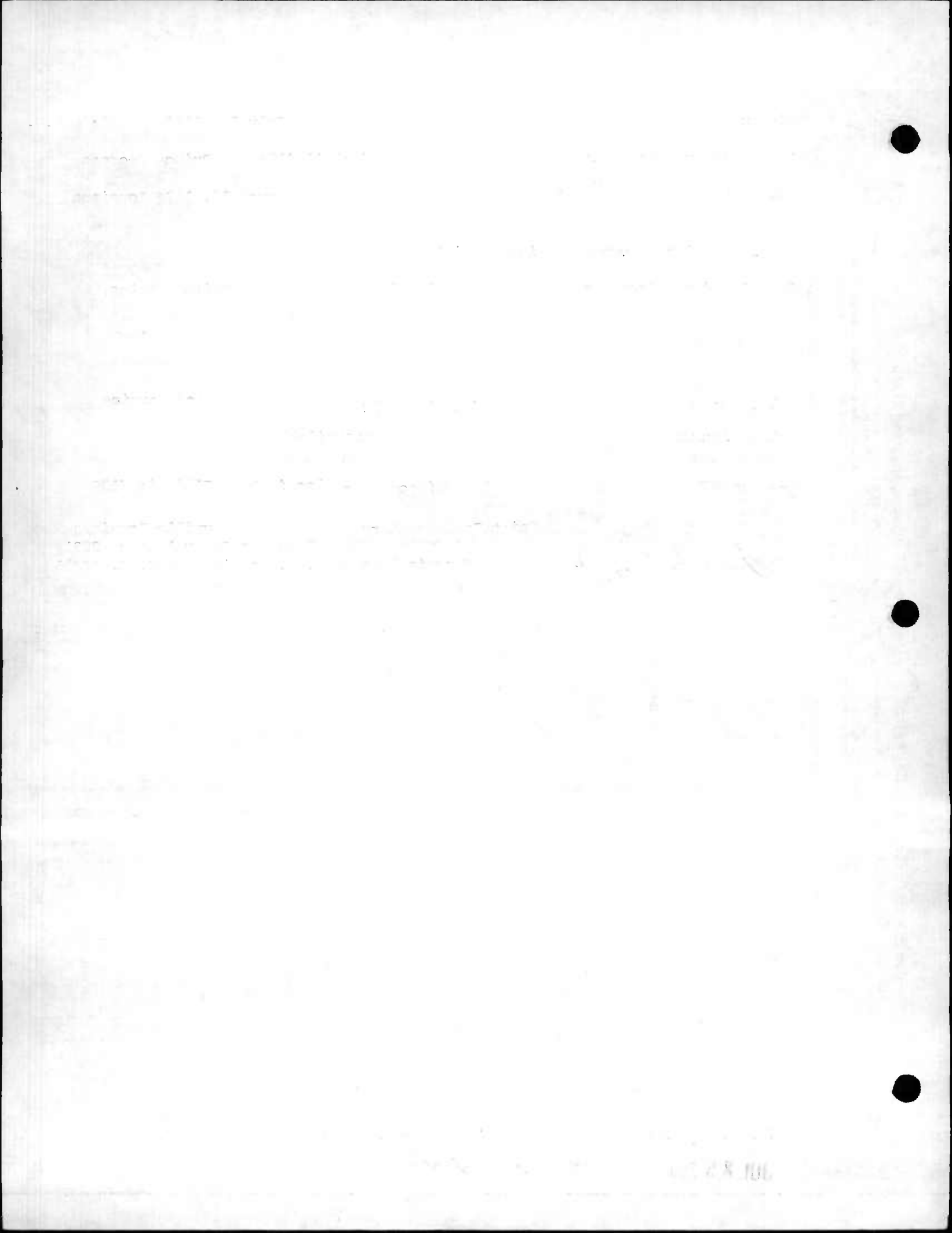
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene 00 23373

amended item 018 per fh g785 wj 7-25-00

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                  |                                                                                                                                                                                              |                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><u>LAWRENCE POWELL</u>                         |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <u>07</u> Day <u>20</u> Year <u>00</u> |                                                                                                                                                                                              | 3. Time of Death<br><u>1645</u>                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><u>Bon Secours Hosp.</u> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><u>BALTO CITY</u>        |                                                                                                                                                                                              | 4c. County of Death<br><u>BALTO CITY</u>       |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><u>227-50-3606</u>                                            | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><u>60</u> Yrs.                 | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. Date of Birth (Month, Day, Year)<br><u>NOV. 18, 1939</u>                                |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><u>VIRGINIA</u>      |                                                                                                                                                                                              |                                                |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                  |                                                                                                                                                                                              |                                                |
| 10a. State<br><u>MARYLAND</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                            | 10b. County<br><u>N/A</u>                                                                                                                                                                                                                                                                   |                                                                  | 10c. City, Town or Location<br><u>BALTIMORE CITY</u>                                                                                                                                         |                                                |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                  |                                                                                                                                                                                              |                                                |
| 10e. Street and Number<br><u>8039 WEST LANVALE STREET</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><u>21216</u>                                    |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><u>U.S.A.</u> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                  |                                                                                                                                                                                              |                                                |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>7TH GRADE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>TRUCK DRIVER</u>                                                                                                                                                            |                                                                  | 16b. Kind of Business/Industry<br><u>TRUCKING COMPANY</u>                                                                                                                                    |                                                |
| 17. Father's Name (First, Middle, Last)<br><u>WILLIE D. POWELL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>MARTHA A. MACKLIN</u>                                                                                                                                                                                                               |                                                                  |                                                                                                                                                                                              |                                                |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>DONNA M. POWELL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>8039 W. LANVALE ST., BALTIMORE, MARYLAND 21216</u>                                                                                                                                      |                                                                  |                                                                                                                                                                                              |                                                |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>WESTVIEW EAST CEMETERY</u>                                                                                                                                                                                     |                                                                  | 20c. Location - City or Town, State<br><u>7-85-00 SOUTH HILL, VA</u>                                                                                                                         |                                                |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            | 22. Name and Address of Facility<br><u>JOSEPH H. BROWN JR. FUNERAL HOME</u><br><u>2140 N. FULTON AVENUE, BALTIMORE, MD 21217</u>                                                                                                                                                            |                                                                  |                                                                                                                                                                                              |                                                |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <u>Arrhythmia</u><br>Due to (or as a consequence of):<br>b. <u>Cardiomyopathy</u><br>Due to (or as a consequence of):<br>c. <u>Hypertension</u><br>Due to (or as a consequence of):<br>d. <u>obesity</u> |                                                                                            | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                                  |                                                                                                                                                                                              |                                                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypercholesterolemia</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                                  |                                                                                                                                                                                              |                                                |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |                                                                  |                                                                                                                                                                                              |                                                |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                  |                                                                                                                                                                                              |                                                |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                  | 28b. Time of Injury<br><u>M</u>                                                                                                                                                              |                                                |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                          |                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                  |                                                                                                                                                                                              |                                                |
| 29b. Signature and title of certifier<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            | 29c. License number<br><u>D25373</u>                                                                                                                                                                                                                                                        |                                                                  | 29d. Date signed (Month, Day, Year)<br><u>July 21, 2000</u>                                                                                                                                  |                                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>NEERJA HUNTING 2900 S HAMMOND ST. BALTO, MD 21225</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                  |                                                                                                                                                                                              |                                                |
| 31. Date filed (Month, Day, Year)<br><u>JUL 25 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                                                                                                                                                             |                                                                  |                                                                                                                                                                                              |                                                |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23374

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alton P Palmer

2. Date of Death

Month Day Year  
July 23 2000

3. Time of Death

12:10 PM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-30-0285

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11-26-35

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

116 N. PACA STREET

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7TH GRADE

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

AUTO MECHANIC

16b. Kind of Business/Industry

BALD. CITY

17. Father's Name (First, Middle, Last)

MOSES PALMER

18. Mother's Name (First, Middle, Maiden Summa)

ROSETTA GREEN

19a. Informant's Name/Relationship (Type, Print)

FLORENCE BELTON | SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

714 PORTLAND ST., BALTO. MD 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MARYLAND NATIONAL

Data

7-27-00

20c. Location - City or Town, State

LAUREL, MD

21. Signature of Funeral Service Licensee

Vaughn C H

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE  
5151 BALD. NATL PIKE, BALD. MD, 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Congestive heart failure

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicidal 4 ☐ Homicidal28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28d. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John Schmittner MD

29c. License number

P 14137

29d. Date signed (Month, Day, Year)

July 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Schmittner 5601 Loch Raven Boulevard Baltimore, MD 21239

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Benjamin S Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
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/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23375

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----------------------|------------------------------------------------------------------|----|-------------------|----------------|----|--------------------------|----------------|----|--------------------------------|------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>MARY E. PRICE</b>                                 |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>2000</b> |                                                                                  |                                                        |                                                                                                | 3. Time of Death<br><b>22:10</b>                      |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not Institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |                                                                                  |                                                        |                                                                                                | 4c. County of Death<br><b>N/A</b>                     |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>214. 16. 8534</b>                                                |                                                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                     |                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>04-14-21</b> |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                      |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  | 10b. County<br><b>N/A</b>                                                                                                                         |                                                                            | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                              |                                                                      |                                                                                  |                                                        | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 10e. Street and Number<br><b>3319 SHANNON DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                                                                                                                                                   |                                                                            | 10f. Zip Code<br><b>21213</b>                                                                                                                                                                |                                                                      |                                                                                  |                                                        | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      |                                                                                  |                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 TH GRADE</b><br>College (1-4 or 5+) <b>2 YRS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                   |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EDUCATOR</b>                                                                 |                                                                      |                                                                                  |                                                        | 16b. Kind of Business/Industry<br><b>BALTO. CITY SCHOOLS</b>                                   |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN SHAW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                   |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY</b>                                                                                                                             |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>YVONNE ALLEN DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                                                                                                                                                   |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3315 SHANNON DR., BALTO. MD. 21213</b>                                                   |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                   |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTO. NATL CEMETERY</b>                                                                                        |                                                                      |                                                                                  |                                                        | 20c. Location - City or Town, State<br><b>1.24.00 BALTO. MD</b>                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 21. Signature of Funeral Service Licensee<br><b>Phon. Mas</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br><b>VAUGHN C. GREENE FUNERAL SERVICE</b>                                                                                                                  |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Seemingly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Ischemic Bowel</b></td> <td>Approximate Interval Between Onset and Death<br/><b>One month</b></td> </tr> <tr> <td>b.</td> <td><b>ESRD on HD</b></td> <td><b>2 years</b></td> </tr> <tr> <td>c.</td> <td><b>Diabetes mellitus</b></td> <td><b>6 years</b></td> </tr> <tr> <td>d.</td> <td><b>Enterocutaneous fistula</b></td> <td><b>one month</b></td> </tr> </table> |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       | Immediate Cause (Final disease or condition resulting in death)<br><br>Seemingly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Ischemic Bowel</b> | Approximate Interval Between Onset and Death<br><b>One month</b> | b. | <b>ESRD on HD</b> | <b>2 years</b> | c. | <b>Diabetes mellitus</b> | <b>6 years</b> | d. | <b>Enterocutaneous fistula</b> | <b>one month</b> |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Seemingly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | a.                                                                                               | <b>Ischemic Bowel</b>                                                                                                                             | Approximate Interval Between Onset and Death<br><b>One month</b>           |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | b.                                                                                               | <b>ESRD on HD</b>                                                                                                                                 | <b>2 years</b>                                                             |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | c.                                                                                               | <b>Diabetes mellitus</b>                                                                                                                          | <b>6 years</b>                                                             |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | d.                                                                                               | <b>Enterocutaneous fistula</b>                                                                                                                    | <b>one month</b>                                                           |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Vaginal cancer, GERD</b><br><b>Decubitus ulcers, PVD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  | 28a. Date of Injury (Month, Day Year)                                                                                                             |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                        | 28d. Describe how injury occurred                                                              |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 29b. Signature and title of certifier<br><b>Dr. Popat, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                                                                                                                                                   |                                                                            | 29c. License number<br><b>D0055259</b>                                                                                                                                                       |                                                                      |                                                                                  |                                                        | 29d. Date signed (Month, Day, Year)<br><b>July 19, 2000</b>                                    |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vaishali Popat 201, East Uni pkway, Balto, MD 21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br><b>Benjamin B Sparks</b>                                                                                                                                        |                                                                      |                                                                                  |                                                        |                                                                                                |                                                       |                                                                                                                                                                                                                                |    |                       |                                                                  |    |                   |                |    |                          |                |    |                                |                  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 23376

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><i>Henry Pierce</i>                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              | 2. Date of Death<br>Month <i>July</i> Day <i>19</i> Year <i>2000</i> |                                                                                  | 3. Time of Death<br><i>3:13 pm</i>                                                                                                                                                               |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><i>University of Maryland Medical System</i> |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><i>Baltimore</i>             |                                                                                  | 4c. County of Death<br><i>N/A</i>                                                                                                                                                                |                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><i>218-78-6314</i>                                                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><i>39</i> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth (Month, Day, Year)<br><i>Oct. 22, 1960</i>                      |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                                                    |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
| 10a. State<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                | 10b. County<br><i>Anne Arundel</i>                                                                                                                                                                                                                                                          |                                                  | 10c. City, Town or Location<br><i>Annapolis</i>                                                                                                                                              |                                                                      |                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                                             |
| 10e. Street and Number<br><i>130 Hearne Rd. Apt. 810</i>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  | 10f. Zip Code<br><i>21401</i>                                                                                                                                                                |                                                                      | 10g. Citizen of What Country?<br><i>United States</i>                            |                                                                                                                                                                                                  |                                                             |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                     |                                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                                                                                                                          |                                                             |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                       |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Data Entry Operator</i>                                                      |                                                                      |                                                                                  | 16b. Kind of Business/Industry<br><i>Census Bureau</i>                                                                                                                                           |                                                             |
| 17. Father's Name (First, Middle, Last)<br><i>Henry William Pierce</i>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Edith E. Stuart</i>                                                                                                                  |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>David R. Pierce/ Brother</i>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4037 S. Rome St. Aurora, CO 80018</i>                                                    |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                              |                                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Chesapeake Crematory, Inc.</i>                                                                                                                                                                                 |                                                  | Date<br><i>7/24/00</i>                                                                                                                                                                       |                                                                      | 20c. Location - City or Town, State<br><i>Beltsville, MD</i>                     |                                                                                                                                                                                                  |                                                             |
| 21. Signature of Funeral Service Licensee<br><i>Laura C. Hardesty</i>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  | 22. Name and Address of Facility<br><i>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Drive Baltimore, MD 21286</i>                                                                   |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death                |
| a. <i>Multisystem Organ Failure</i><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  | <i>1 month</i>                                              |
| b. <i>Sepsis</i><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  | <i>1 month</i>                                              |
| c. <i>Acute Respiratory Distress Syndrome</i><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  | <i>1 week</i>                                               |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                             |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                             |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                         |                                                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. Time of Injury<br>M                                                                                                                                                                     |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  | 28d. Describe how Injury occurred                           |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                       |                                                                                                                | 29b. Signature and title of certifier<br><i>Gary Coke</i>                                                                                                                                                                                                                                   |                                                  | 29c. License number<br><i>12485</i>                                                                                                                                                          |                                                                      | 29d. Date signed (Month, Day, Year)<br><i>7/19/2000</i>                          |                                                                                                                                                                                                  |                                                             |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Gary Coke 22 South Greene St, Baltimore, Maryland 21201</i>                                                                                                                                                                                                                                                                                             |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |
| 31. Date filed (Month, Day, Year)<br><i>JUL 25 2000</i>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                | 32. Registrar's Signature<br><i>Geneva B. Sparks</i>                                                                                                                                                                                                                                        |                                                  |                                                                                                                                                                                              |                                                                      |                                                                                  |                                                                                                                                                                                                  |                                                             |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

00 23377

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                     |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Pauline Marie Parrott                   |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 18 2000 |                                                      | 3. Time of Death<br>17:43                                                                          |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>St Agnes Hospital |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Baltimore  |                                                      | 4c. County of Death<br>N/A                                                                         |                                                                                                                                                                                                          |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>219.18.5831                                            | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br>76 Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                                                                                                                          | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth (Month, Day, Year)<br>May 3, 1924   |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Virginia                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                         |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     | 10b. County<br>Howard                                                                                                                                 |                                           | 10c. City, Town or Location<br>Elkridge                                                                                                                                                                                                                                                                 |                                                    |                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                                                                                          |
| 10e. Street and Number<br>6421 Loudon Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                     |                                                                                                                                                       |                                           | 10f. Zip Code<br>21075                                                                                                                                                                                                                                                                                  |                                                    | 10g. Citizen of What Country?<br>U.S.A.              |                                                                                                    |                                                                                                                                                                                                          |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                       |                                                    |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                                                                                                                                                                          |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                     |                                                                                                                                                       |                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                  |                                                    |                                                      | 16b. Kind of Business/Industry<br>Own Home                                                         |                                                                                                                                                                                                          |
| 17. Father's Name (First, Middle, Last)<br>Walter Garrison                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     |                                                                                                                                                       |                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>Edith Snead                                                                                                                                                                                                                                        |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |
| 19a. Informant's Name/Relationship (Type, Print)<br>Albert G. Parrott/Husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                     |                                                                                                                                                       |                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6421 Loudon Avenue Elkridge, MD. 21075                                                                                                                                                                 |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                     |                                                                                                                                                       |                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Mem. Pk. 7/22                                                                                                                                                                                                     |                                                    | 20c. Location - City or Town, State<br>Elkridge, Md. |                                                                                                    |                                                                                                                                                                                                          |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                     |                                                                                                                                                       |                                           | 22. Name and Address of Facility Gary L. Kaufman Funeral Home<br>7250 Washington Blvd. Elkridge, MD 21075                                                                                                                                                                                               |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Anoxic Encephalopathy<br>Due to (or as a consequence of):<br>b. Myocardial Infarction<br>Due to (or as a consequence of):<br>c. Coronary Artery Disease<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                     |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         |                                                    |                                                      |                                                                                                    | Approximate Interval Between Onset and Death<br>2-days<br>2-days<br>5 years                                                                                                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         |                                                    |                                                      |                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                     |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         |                                                    |                                                      |                                                                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                     |                                                                                                                                                       |                                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                          |                                                                                     |                                                                                                                                                       |                                           | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                    | 28b. Time of Injury<br>M                             |                                                                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                     |                                                                                                                                                       |                                           | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                    |                                                      | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                       |                                                                                                                                                                                                          |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |
| 29b. Signature and title of certifier<br><i>[Signature]</i> J. Lewis MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                     |                                                                                                                                                       |                                           | 29c. License number<br>P13597                                                                                                                                                                                                                                                                           |                                                    | 29d. Date signed (Month, Day, Year)<br>July 18, 2000 |                                                                                                    |                                                                                                                                                                                                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Martin's Ugwu-Dike, MD 900 Caton Ave, Baltimore MD 21229                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                         |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                                                       |                                           | 32. Registrar's Signature<br><i>[Signature]</i> Sparks                                                                                                                                                                                                                                                  |                                                    |                                                      |                                                                                                    |                                                                                                                                                                                                          |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

6786 8-28-00 WR.  
Certificate of Death

00 23378

AMEND ITEMS: #23 PART I, 27 PER MEO

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><b>RAMONA SUE RYAN</b>                                |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month <b>JULY</b> Day <b>19</b> Year <b>2000</b> |                                                             |                                                            |                                                                                                    | 3. Time of Death<br><b>2109</b>                                  |  |
|                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b> |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>ESSEX</b>                 |                                                             |                                                            |                                                                                                    | 4c. County of Death<br><b>BALTIMORE</b>                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                             | 5. Social Security Number<br><b>236-84-4181</b>                                                   |                                                                                                                                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.                     |                                                             | 8. Date of Birth (Month, Day, Year)<br><b>Jan 12, 1935</b> |                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |  |
|                                                                                                                                                                                                                                                                 | Usual Residence of Decedent                                                                       |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 10a. State<br><b>Md</b>                                                                                                                                                                                                                                         |                                                                                                   | 10b. County                                                                                                                                           |                                                                                | 10c. City, Town or Location<br><b>Upper Falls</b>                                                                                                                                                |                                                                      |                                                             |                                                            | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                  |  |
| 10e. Street and Number<br><b>7726 Bradshaw Road</b>                                                                                                                                                                                                             |                                                                                                   |                                                                                                                                                       |                                                                                | 10f. Zip Code<br><b>21156</b>                                                                                                                                                                    |                                                                      | 10g. Citizen of What Country?<br><b>USA</b>                 |                                                            |                                                                                                    |                                                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                          |                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                      |                                                             |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                    |                                                                      |                                                             |                                                            | 16b. Kind of Business/Industry<br><b>own home</b>                                                  |                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Orville Thomas</b>                                                                                                                                                                                                |                                                                                                   |                                                                                                                                                       |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tina Vance Brady</b>                                                                                                                     |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John C Ryan / husband</b>                                                                                                                                                                                |                                                                                                   |                                                                                                                                                       |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7726 Bradshaw Road Upper Falls Md. 21156</b>                                                 |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                 |                                                                                                   |                                                                                                                                                       |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Schumate Cemetery</b>                                                                                               |                                                                      | 20c. Location - City or Town, State<br><b>West Virginia</b> |                                                            | 20d. Date<br><b>7/24/2000</b>                                                                      |                                                                  |  |
| 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore MD. 21221</b>                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>MYOCYTE HYPERTROPHY AND MYOCARDIAL FIBROSIS</b> |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23b. Approximate Interval Between Onset and Death                                                                                                                                                                                                               |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23c. Immediate Cause (Final disease or condition resulting in death)<br><b>MYOCYTE HYPERTROPHY AND MYOCARDIAL FIBROSIS</b>                                                                                                                                      |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23d. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23e. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23f. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23g. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23h. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23i. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23j. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23k. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23l. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23m. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23n. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23o. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23p. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23q. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23r. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23s. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23t. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23u. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23v. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23w. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23x. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23y. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23z. Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23aa. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ab. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ac. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ad. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ae. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23af. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ag. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ah. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ai. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23aj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ak. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23al. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23am. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23an. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ao. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ap. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23aq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ar. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23as. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23at. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23au. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23av. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23aw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ax. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ay. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23az. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ba. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bd. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23be. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bf. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bi. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bk. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bl. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bm. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bn. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bo. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23br. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bs. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bt. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bu. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23by. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23bz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ca. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cd. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ce. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cf. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ch. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ci. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ck. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cl. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cm. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cn. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23co. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cr. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cs. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ct. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cu. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cy. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23cz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23da. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23db. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dd. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23de. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23df. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23di. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dk. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dl. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dm. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dn. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23do. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dr. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ds. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dt. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23du. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dy. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23dz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ea. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23eb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ec. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ed. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ee. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ef. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23eg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23eh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ei. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ej. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ek. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23el. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23em. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23en. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23eo. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ep. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23eq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23er. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23es. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23et. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23eu. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ev. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ew. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ex. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ey. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ez. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fa. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fd. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fe. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ff. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fi. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fk. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fl. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fm. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fn. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fo. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fr. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fs. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ft. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fu. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fy. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23fz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ga. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gd. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ge. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gf. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gi. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gk. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gl. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gm. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gn. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23go. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gr. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gs. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gt. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gu. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gy. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23gz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ha. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hd. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23he. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hf. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hi. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hk. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hl. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hm. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hn. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ho. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hr. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hs. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ht. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hu. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hy. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23hz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ia. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ib. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ic. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23id. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ie. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23if. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ig. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ih. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ii. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ij. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ik. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23il. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23im. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23in. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23io. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ip. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23iq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ir. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23is. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23it. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23iu. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23iv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23iw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ix. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23iy. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23iz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ja. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jd. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23je. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jf. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ji. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jk. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jl. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jm. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jn. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jo. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jr. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23js. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jt. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ju. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jy. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23jz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ka. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kd. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ke. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kf. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ki. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kk. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kl. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23km. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kn. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ko. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kr. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ks. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kt. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ku. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ky. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23kz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23la. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lb. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lc. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ld. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23le. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lf. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lg. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lh. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23li. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lj. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lk. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ll. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lm. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ln. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lo. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lp. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lq. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lr. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ls. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lt. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lu. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lv. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lw. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lx. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ly. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23lz. Due to (or as a consequence of):                                                                                                                                                                                                                          |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |
| 23ma. Due to (or as a consequence of):</                                                                                                                                                                                                                        |                                                                                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                                      |                                                             |                                                            |                                                                                                    |                                                                  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23379

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Reier

2. Date of Death

July 23, 2000

3. Time of Death

16:30

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

-

Funeral  
Director

5. Social Security Number

215-34-1095

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

DEC 20, 1937

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2629 PROCTOR LANE

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: AIR FORCE

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUS DRIVER

16b. Kind of Business/Industry

GOLDEN RING  
BUS TOURS

17. Father's Name (First, Middle, Last)

CARL S. REIER

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE A. MACKENZIE

19e. Informant's Name/Relationship (Type, Print)

LINDA J. REIER, SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2629 PROCTOR LN. PARKVILLE, MD. 21234

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

JULY 27, 2000

20c. Location - City or Town, State

PARKVILLE, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL

3800 HARFORD RD. PARKVILLE, MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LIVER FAILURE

Due to (or as a consequence of):

b. Alcoholic Cirrhosis

Due to (or as a consequence of):

c. Alcoholism

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 month

3 months

20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alain Bertoni MD

29c. License number

D0053444

29d. Date signed (Month, Day, Year)

July 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alain Bertoni 5601 Loch Raven Boulevard Baltimore MD 21239

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

[Signature]

State Registrar

15

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-342-2000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





00 23380

Amended item# 10f per fh g785 7-31-00 w/

Physician /Medical Examiner

2. Date of Death  
Month JULY Day 18 Year 2000 10:15 AM

1. Decedent's Name (First, Middle, Last)  
FRANCES E. ROHRBAUGH

4a. Facility Name (If not institution, give street and number)  
Saint Joseph Medical Center

4b. City, Town, or Location of Death  
Towson

4c. County of Death  
Baltimore

Funeral Director

5. Social Security Number  
411-44-3697

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
80 Yrs.

8. Date of Birth (Month, Day, Year)  
10/06/1919

9. Birthplace (State or Foreign Country)  
KANSAS

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location  
BALTIMORE CITY

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number  
6201 LOCH RAVEN BLVD. APT 601

10f. Zip Code  
21239

10g. Citizen of What Country?  
U.S.A.

11. Marital Status  
1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 3 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
MEDICAL TECHNOLOGIST

16b. Kind of Business/Industry  
HOSPITAL

17. Father's Name (First, Middle, Last)  
FRANKLIN HOWE ROHRBAUGH

18. Mother's Name (First, Middle, Maiden Surname)  
MARGARET MAY MURPHY

19a. Informant's Name/Relationship (Type, Print)  
HELEN VAUGHT / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
11 SANDPINE CT. EAST; HOMOSASSA, FL 34446

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
PARKWOOD CEMETERY

20c. Location - City or Town, State  
7/22 BALTIMORE CITY, MD

21. Signature of Funeral Service Licensee  
Heather N. Harper

22. Name and Address of Facility  
THE JOHNSON FUNERAL HOME, P.A.  
8521 LOCH RAVEN BLVD.; TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
MYOCARDIAL INFARCTION  
a. Due to (or as a consequence of):  
PULMONARY EMBOLISM  
b. Due to (or as a consequence of):  
PERFORATED CECUM  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
DAYS  
HOURS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
CONGESTIVE HEART FAILURE  
ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
Erlando Romero

29c. License number  
D28982

29d. Date signed (Month, Day, Year)  
7/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
ERLANDO ROMERO M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)  
JUL 25 2000

32. Registrar's Signature  
Benjamin Sparks

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23381

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lois Robinson

2. Date of Death

Month Day Year  
July 22, 2000

3. Time of Death

2:10Am

4a. Facility Name (If not institution, give street and number)

Eastpoint Rehab. and Nursing Center

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-22-8104

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 3, 1925

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3126 Liberty Parkway

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8 yrs.

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Leon Mowery

18. Mother's Name (First, Middle, Maiden Surname)

Adel Lloyd

19a. Informant's Name/Relationship (Type, Print)

Roderick Robinson son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

219 St. Helena Ave. Dundalk Md. 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

July 25, 2000

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensor

*[Signature]*

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk  
7110 Sollers Point Rd. 21222

23a. Pert.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 mos

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE, CHF, HTN, COPD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D45757

29d. Date signed (Month, Day, Year)

JULY 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW MCNABNEY 5505 HOPKINS BAYVIEW LUCHE BAL MD 21224

31. Date filed (Month, Day, Year)

JUL 24 2000

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#16A &amp; 20B PER F.H. G785 7-28-200 JAB

## Certificate of Death

Reg. No.

00 23382

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>JOYCE ANN SYE</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                   |                                       | 2. Date of Death<br>Month <b>7</b> Day <b>23</b> Year <b>2000</b>                                                                                                                               |                                                                                                | 3. Time of Death<br><b>3:35 AM</b>                                      |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>ST. AGNES HEALTH CARE</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                   |                                       | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                        |                                                                                                | 4c. County of Death<br><b>N/A</b>                                       |                                                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>213-60-2173</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.                                                                                                  | If Under 1 Year<br>Months             | If Under 24 Hrs.<br>Hours                                                                                                                                                                       | 6. Date of Birth (Month, Day, Year)<br><b>NOV, 27, 1954</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>             |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10b. County<br><b>N/A</b>                                                  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                   |                                       |                                                                                                                                                                                                 | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>3508 WEST FOREST PARK AVE.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                   | 10f. Zip Code<br><b>21216</b>         |                                                                                                                                                                                                 | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                 |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                 |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | College (1-4 or 5+) <b>N/A</b>                                                                                                                    |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MEDICAL METAL RECORD CLERK</b>                                                  |                                                                                                | 16b. Kind of Business/Industry<br><b>PRIVATE COMPANY</b>                |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>ROY CLARENCE BOND</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE L. STARKEY</b>                                                                                                                    |                                                                                                |                                                                         |                                                                              |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | 19e. Informant's Name/Relationship (Type, Print)<br><b>CONNIE BOND</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3508 WEST FOREST PARK AVE. BALTO. MD. 21216</b>                                             |                                                                                                |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                          |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETERY</b>                                                |                                       | Data<br><b>7-31-00</b>                                                                                                                                                                          |                                                                                                | 20c. Location - City or Town, State<br><b>WOODLAWN, MARYLAND</b>        |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br><b>Lewis T. Gwynn</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>LEWIS T. GWYNN FUNERAL HOME<br/>4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393</b>                            |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Colon carcinom with metastasis to lung.</b><br>Due to (or as a consequence of):<br><b>b. lung.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 28a. Date of Injury (Month, Day, Year)                                     |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>       |                                                                                                                                                                                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |                                                                         | 28d. Describe how injury occurred                                            |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 29b. Signature and title of certifier<br><b>R. Pandya</b>                  |                                                                                                                                                   | 29c. License number<br><b>P-12599</b> |                                                                                                                                                                                                 | 29d. Date signed (Month, Day, Year)<br><b>7/23/2000</b>                                        |                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MANISH PANDYA, MD, 900 CATON AVE, BALTIMORE, MD - 21229.</b>                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 32. Registrar's Signature<br><b>Beverly S. Sparks</b>                      |                                                                                                                                                   |                                       |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                              |  |

x

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23383

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|-------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>Alice G. Streett</b>                                                                                                                                                                                                                                                                                                                   |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> , Year <b>2000</b>                                                                                                                           |                                                                                      |                                                             |                                                                         | 3. Time of Death<br><b>9:19 a.m.</b>                                                               |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Holly Hill Nursing Home</b>                                                                                                                                                                                                                                                                                      |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Towson</b>                                                                                                                                            |                                                                                      |                                                             |                                                                         | 4c. County of Death<br><b>Baltimore Co.</b>                                                        |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>215-24-2310</b>                                                                                                                                                                                                                                                                                                                                       |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                                                                                                                                                 |                                                                                      | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 31, 1915</b> |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>                                  |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                           |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                         |                                       | 10b. County<br><b>Baltimore</b>                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br><b>Dundalk</b>                                                                                                                                                    |                                                                                      |                                                             |                                                                         | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br><b>306 Bayside Drive</b>                                                                                                                                                                                                                                                                                                                                    |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br><b>21222</b>                                                                                                                                                                    |                                                                                      | 10g. Citizen of What Country?<br><b>United States</b>       |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>3 years</b>                                                                                                                                                                                                                                                  |                                       |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>                                                                                                                                                                    |                                                                                                                                                                                                  |                                                                                      | 16b. Kind of Business/Industry<br><b>Health</b>             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br><b>Nathan Godwin</b>                                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosa Belle Strickland</b>                                                                                                                |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jan L. Streett (Son)</b>                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19395 Dutton Road Stewartstown, Pa. 17363</b>                                                |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Stablers Cemetery</b>                                                    |                                                                                                                                                                                                                                                                                                         | 20c. Location - City or Town, State<br><b>7/24/2000 Parkton, Maryland</b>                                                                                                                        |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br><i>Stephanie Moray</i>                                                                                                                                                                                                                                                                                                                   |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Avenue Dundalk, Maryland 21222</b>                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Dementia</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             | Approximate Interval Between Onset and Death<br><b>&gt; 1 yr.</b>                                                                                                                                        |                                                 |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                 |  |                                                       |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                       | 28a. Date of Injury (Month, Day Year) |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                             | 28d. Describe how injury occurred                                       |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |                                                 |  |                                                       |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    | 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                 |                                                                                                                                                                                                          | 29c. License number<br><b>D 2539</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>7-21-00</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. KHAN MD 5601- Loch Raven Blvd, Baltimore MD 21239</b>                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                      |                                                             |                                                                         |                                                                                                    | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                     |                                                                                                                                                                                                          | 32. Registrar's Signature<br><i>[Signature]</i> |  |                                                       |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23384

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Francis Stone, Sr.

2. Date of Death

Month Day Year  
July 21, 2000

3. Time of Death

6:00 PM

4a. Facility Name (If not institution, give street and number)

1747 Brookview Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

407-01-9063

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 20, 1920

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1747 Brookview Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No WWII  
If Yes, Give Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Millwright

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Hasker Stone

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Schuster

19a. Informant's Name/Relationship (Type, Print)

Mary E. Mussard Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1100 Old Mountain Road N. Joppa Maryland 21085

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp. 7/25/ 2000 Towson, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ Johnny L. Stone

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Avenue Baltimore, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC PERIPHERAL VASCULAR DISEASE

RIGHT CAROTID ENDARTERECTOMY, July 19, 2000

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ Calvin E Jones MD

29c. License number

D06251

29d. Date signed (Month, Day, Year)

July 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CALVIN E JONES MD DEPT SURGERY, JOHNS HOPKINS BAYVIEW MED CTR BALTO, MD 21224

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

▶ [Signature]

ORIGINAL

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 00234.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23385

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br>Wilson Simmons                           |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br>June 01 2000                                                                                                                                           |                                                                                             |                                                            |                                                                                                | 3. Time of Death<br>8:20 P.M.                        |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not Institution, give street and number)<br>St. Agnes Hospital |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br>Baltimore                                                                                                                                            |                                                                                             |                                                            |                                                                                                | 4c. County of Death<br>N/A                           |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br>231-38-4609                                             |                                                     | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br>65 Yrs.                                                                                                                                                    |                                                                                             | 8. Date of Birth (Month, Day, Year)<br>Aug. 19, 1934       |                                                                                                | 9. Birthplace (State or Foreign Country)<br>Virginia |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                          |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      | 10b. County<br>N/A                                  |                                                                                                                                                   | 10c. City, Town or Location<br>Baltimore                                                                                                                                                                                                                                                    |                                                                                                                                                                                              |                                                                                             |                                                            | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                      |                                                                                                                                                                                                  |  |
| 10e. Street and Number<br>3416 Piedmont Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                     |                                                                                                                                                   | 10f. Zip Code<br>21216                                                                                                                                                                                                                                                                      |                                                                                                                                                                                              |                                                                                             |                                                            | 10g. Citizen of What Country?<br>USA                                                           |                                                      |                                                                                                                                                                                                  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                               |                                                      |                                                                                                                                                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      |                                                     |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Machine Operator                                                                                                                                                               |                                                                                                                                                                                              |                                                                                             |                                                            | 16b. Kind of Business/Industry<br>Factory                                                      |                                                      |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br>John M. Simmons                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                      |                                                     |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Fannie Mae Garret                                                                                                                                                                                                                      |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Connie Granger, Niece                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                     |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>47700 Wheeler Dr., Arlington, VA 20653                                                                                                                                                     |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                      |                                                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mount Zion                                                              |                                                                                                                                                                                                                                                                                             | Date<br>06-07-00                                                                                                                                                                             |                                                                                             | 20c. Location - City or Town, State<br>Baltimore, Maryland |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                                                     |                                                                                                                                                   | 22. Name and Address of Facility<br>Howell Funeral Home<br>4600 Liberty Heights Ave., Balto., MD 21207                                                                                                                                                                                      |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. Renal Failure and Sepsis<br>Due to (or as a consequence of):<br><br>b. Perforated Esophagus<br>Due to (or as a consequence of):<br><br>c. Ingestion of Corrosive (Lye)<br>Due to (or as a consequence of):<br><br>d. |                                                                                      |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertensive Cardiovascular Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>Approval<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                     |                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                      | 28a. Date of Injury (Month, Day Year)<br>04-22-2000 |                                                                                                                                                   | 28b. Time of Injury<br>8:00 P M                                                                                                                                                                                                                                                             |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                            | 28d. Describe how injury occurred<br>Subject ingested lye.                                     |                                                      |                                                                                                                                                                                                  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                     |                                                                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>3416 Piedmont Ave.<br>Baltimore, Maryland                                                                                                                                                                   |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                         |                                                                                      |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                     |                                                                                                                                                   | 29c. License number<br>O.C.M.E.                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            | 29d. Date signed (Month, Day, Year)<br>July 24, 2000                                           |                                                      |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |                                                     |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      | 32. Registrar's Signature<br>                       |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                             |                                                            |                                                                                                |                                                      |                                                                                                                                                                                                  |  |



ASP

AMEND ITEMS: #23 PART I, 27, 28A-F

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM RAY SEXTON JR.</b>                         |                                 |                                                                                                                                                   |                                                                                                                                     | 2. Date of Death<br>Month Day Year<br><b>JULY 23 2000</b>                                                                                                                                                                                                                                   |                                                                  |                                                             |                                                                                                | 3. Time of Death<br><b>0020</b>                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b> |                                 |                                                                                                                                                   |                                                                                                                                     | 4b. City, Town, or Location of Death<br><b>ESSEX</b>                                                                                                                                                                                                                                        |                                                                  |                                                             |                                                                                                | 4c. County of Death<br><b>BALTIMORE</b>                                                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>216-80-1831</b>                                                   |                                 | 6. Sex<br><b>XXM 20 F</b>                                                                                                                         |                                                                                                                                     | 7. Age (In yrs. last birthday)<br><b>25</b> Yrs.                                                                                                                                                                                                                                            |                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 18 1974</b>  |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                       |                                 |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   | 10b. County<br><b>Baltimore</b> |                                                                                                                                                   | 10c. City, Town or Location<br><b>Essex</b>                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                             |  |
| 10e. Street and Number<br><b>258 Nanticoke Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   |                                 |                                                                                                                                                   | 10f. Zip Code<br><b>21221</b>                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                                             |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                        |                                                                                                   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |                                                                  |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |                                 |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cable Installer</b> |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             | 16b. Kind of Business/Industry<br><b>Telecommunications</b>                                    |                                                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Ray Sexton Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Deborah Forshaw</b>                                                                                                                                                                                                                 |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William R. Sexton Sr. /Father</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>258 Nanticoke Road Baltimore MD. 21221</b>                                                                                                                                              |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                 |                                                                                                   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro CREMATORY Inc. 7/26/2000</b>                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b> |                                                             |                                                                                                |                                                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 MACE AVE. BALTIMORE MD. 21221</b>                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>ELECTROCUTION</b><br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                      |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                          |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                               |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 28a. Date of Injury (Month, Day Year)<br><b>7-22-00</b>                                                                                                                                                                                                                                     |                                                                  | 28b. Time of Injury<br><b>11:32</b>                         |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>YARD OF PRIVATE DWELLING</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 28d. Describe how injury occurred<br><b>Subject made contact with metal pole which was electrified</b>                                                                                                                                                                                      |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>NECK RD. ESSEX, BALTIMORE CO. MD</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                          |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                          |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 29c. License number<br><b>O.C.M.E</b>                                                                                                                                                                                                                                                       |                                                                  | 29d. Date signed (Month, Day, Year)<br><b>JULY 23, 2000</b> |                                                                                                |                                                                                             |  |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                          |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                  |                                                             |                                                                                                |                                                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |                                 |                                                                                                                                                   |                                                                                                                                     | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                  |                                                             |                                                                                                |                                                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23387

|                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |
|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>ANNA MANOS STEVENSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    | 2. Date of Death<br>Month Day Year<br><b>JULY 23, 2000</b>                                                                                      |                                                                         | 3. Time of Death<br><b>9:00 PM</b>                                                             |  |
|                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>8-B FITZGERALD CT.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    | 4b. City, Town, or Location of Death<br><b>CARNEY</b>                                                                                           |                                                                         | 4c. County of Death<br><b>BALTIMORE</b>                                                        |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>215-09-1513</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.                                                                                                                                             |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>NOV 14, 1915</b>                                                                                      |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>                                         |  |
|                                                         | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |
| To Be Completed by Funeral Director                     | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               | 10b. County<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                             |  | 10c. City, Town or Location<br><b>REVERE PARK / CARNEY</b>                                                                                                                                   |                                                                                                                                                    |                                                                                                                                                 |                                                                         | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                                         | 10e. Street and Number<br><b>8-B FITZGERALD CT.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>21234</b>                                                                                                                                                                |                                                                                                                                                    | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                  |                                                                         |                                                                                                |  |
|                                                         | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                 |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                    |                                                                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                                                                |  |
|                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                    |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ASSEMBLY</b>                                                                                                                                                                |  |                                                                                                                                                                                              |                                                                                                                                                    | 16b. Kind of Business/Industry<br><b>BENDIX CORP.</b>                                                                                           |                                                                         |                                                                                                |  |
| To Be Completed by Physician/Medical Examiner           | 17. Father's Name (First, Middle, Last)<br><b>NICHOLAS MANOS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EMMA PHILIPS</b>                                                                        |                                                                         |                                                                                                |  |
|                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>SANDRA EICHLER, DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8-B FITZGERALD CT. BALTIMORE, MD. 21234</b> |                                                                         |                                                                                                |  |
|                                                         | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                          |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND ANATOMY BOARD</b>                                                                                                                                                                                     |  | 20c. Date<br><b>JULY 24</b>                                                                                                                                                                  |                                                                                                                                                    | 20d. Location - City or Town, State<br><b>BALTIMORE MD.</b>                                                                                     |                                                                         |                                                                                                |  |
|                                                         | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    | 22. Name and Address of Facility<br><b>EVANS FUNERAL CHAPEL<br/>8800 HARFORD RD. PARKVILLE, MD. 21234</b>                                       |                                                                         |                                                                                                |  |
| Physician<br>/Medical<br>Examiner                       | 23a. Part I. Enter the disease or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASPIRATION PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. PROBABLE ALZHEIMERS DEMENTIA</b><br>Due to (or as a consequence of):<br><b>c. CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br><b>d.</b> |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |
|                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                               |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |
|                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                 |                                                                         |                                                                                                |  |
|                                                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |
| To Be Completed by Physician/Medical Examiner           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                              |                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |
|                                                         | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                     |                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                                                                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                     |                                                                         | 28d. Describe how injury occurred                                                              |  |
|                                                         | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                    |                                                                         |                                                                                                |  |
|                                                         | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                   |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |
| State Registrar                                         | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>D4000 8</b>                                                                                                                                                        |                                                                                                                                                    | 29d. Date signed (Month, Day, Year)<br><b>JULY 24, 2000</b>                                                                                     |                                                                         |                                                                                                |  |
|                                                         | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES PARSHALL, MD. 9105 FRANKLIN SQ. DR. ROSEDALE, MD. 21237</b>                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                                                                                 |                                                                         |                                                                                                |  |

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State of Maryland / Department of Health and Mental Hygiene

00 23388

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Scriven</b>                                  |                                                                                                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br><b>July 22, 2000</b>                                                                                                |                                                                                                                                                                                              | 3. Time of Death<br><b>8:14am</b>           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hosiptal</b> |                                                                                                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                  |                                                                                                                                                                                              | 4c. County of Death<br><b>NA</b>            |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>239-05-7219</b>                                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                                                                                                          | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br><b>06-06-15</b>                                           |                                                                                                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>SC</b>                                                                                                     |                                                                                                                                                                                              |                                             |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  | 10b. County<br><b>NA</b>                                                                                                                                                                                                                                                                 |                                                                                                                                                           | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                              |                                             |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 10e. Street and Number<br><b>2213 E. Hennenan Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                                                                                                                                                                                                                                                          | 10f. Zip Code<br><b>21213</b>                                                                                                                             |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>USA</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                        |                                                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                             |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th Grade</b><br>College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurses Aid</b>                                                                                                                                                           |                                                                                                                                                           | 16b. Kind of Business/Industry<br><b>Edgewood N.H.</b>                                                                                                                                       |                                             |
| 17. Father's Name (First, Middle, Last)<br><b>Henry McCall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  |                                                                                                                                                                                                                                                                                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma McCall</b>                                                                                   |                                                                                                                                                                                              |                                             |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Saulsbury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                                                                                                                                                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2213 E. Hennenan Avenue Baltimore, Maryland 21213</b> |                                                                                                                                                                                              |                                             |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                   |                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Voshell Mem. Gardens</b>                                                                                                                                                                                    |                                                                                                                                                           | 20c. Location - City or Town, State<br><b>07-28-2000 Dundalk, MD</b>                                                                                                                         |                                             |
| 21. Signature of Funeral Service Licensee<br><b>Gabriele Cook</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C.March FH 1101 East North Avenue</b>                                                                                                                                                                      |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ASCVD</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>old CVA</b><br><b>Hypertension</b> |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure</b><br><b>old CVA</b><br><b>Hypertension</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                           |                                                                                                  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                    |                                                                                                                                                           | 28b. Time of injury<br><b>M</b>                                                                                                                                                              |                                             |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                        |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                             |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                               |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 29b. Signature and title of certifier<br><b>Spencer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  | 29c. License number<br><b>D28987</b>                                                                                                                                                                                                                                                     |                                                                                                                                                           | 29d. Date signed (Month, Day, Year)<br><b>7/24/2000</b>                                                                                                                                      |                                             |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CARL SPERLING MD 5601 LOCH RAVEN BLVD BALTO. MD 21239</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                                                                                                                                                                                                                                                          |                                                                                                                                                           |                                                                                                                                                                                              |                                             |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  | 32. Registrar's Signature<br><b>Benjamin A. Adams</b>                                                                                                                                                                                                                                    |                                                                                                                                                           |                                                                                                                                                                                              |                                             |

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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>FAITH B STEWART</b>                                    |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>07</b> Day <b>21</b> Year <b>2000</b> |                                                                                                | 3. Time of Death<br><b>8:15 AM</b>                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>UNIV MARYLAND MEDICAL SYSTEM</b> |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Baltimore</b>           |                                                                                                | 4c. County of Death<br><b>Baltimore City</b>                                                                                                                                                     |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>218-26-8929</b>                                                       | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                     | 8. Date of Birth (Month, Day, Year)<br><b>10/31/32</b>                                         | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Usual Residence of Decedent                                                                           |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                    |                                                                                                |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                       | 10b. County                                                                                                                                                                                                                                                                                 |                                                  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                              |                                                                    | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>1835 E BALTO. ST APT. C</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  | 10f. Zip Code<br><b>21231</b>                                                                                                                                                                |                                                                    | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                          |                                                                                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                    | 14. Race - American Indian, Black, White, etc.<br><b>AFRO</b><br>Specify: <b>AMERICAN</b>      |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CUSTODIAN</b>                                                                |                                                                    | 16b. Kind of Business/Industry<br><b>C.C.B</b>                                                 |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES C HARRIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES HARRIS</b>                                                                                                                   |                                                                    |                                                                                                |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PHILLIP STEWART</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1835 E. BALTO ST. BALTO. MD 21231 (APT C)</b>                                            |                                                                    |                                                                                                |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                   |                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN PARK</b>                                                                                                                                                                                              |                                                  | Date<br><b>7/28/2000</b>                                                                                                                                                                     |                                                                    | 20c. Location - City or Town, State<br><b>WOODLAWN MD.</b>                                     |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br><b>Phillip Stewart</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PL BALTO. MD 21217</b>                                                                                 |                                                                    |                                                                                                |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><br>b. <b>Hypotension</b><br>Due to (or as a consequence of):<br><br>c. <b>GI dysfunction</b><br>Due to (or as a consequence of):<br><br>d. <b>Duodenal Adenocarcinoma</b> |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                    |                                                                                                | Approximate Interval Between Onset and Death<br><br><b>12hrs</b><br><br><b>24hrs</b><br><br><b>1 year</b><br><br><b>1 year</b>                                                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                    |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                    |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                              |                                                                    |                                                                                                |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                           |                                                                                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. Time of Injury<br>M                                                                                                                                                                     |                                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                                                                                                                                                                  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                    |                                                                                                |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                               |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                    |                                                                                                |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br><b>Wendy A. Welch MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  | 29c. License number<br><b>13158</b>                                                                                                                                                          |                                                                    | 29d. Date signed (Month, Day, Year)<br><b>7/21/00</b>                                          |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>UMMS, 225 Greene Street, Baltimore, MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                              |                                                                    |                                                                                                |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                  | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                |                                                                    |                                                                                                |                                                                                                                                                                                                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23390

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1. Decedent's Name (First, Middle, Last)<br>Henry A. Seiler                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br>July 16, 2000 |                                                                                      |                                                      |                                                                                                    | 3. Time of Death<br>13:50                            |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4a. Facility Name (If not institution, give street and number)<br>Howard County General Hospital |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br>Columbia    |                                                                                      |                                                      |                                                                                                    | 4c. County of Death<br>Howard                        |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5. Social Security Number<br>215-12-0238                                                         |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>76 Yrs.           |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Oct. 24, 1923 |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Usual Residence of Decedent                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  | 10b. County<br>Howard                                                                                                                                                                                                                                                                                   |                                                                                | 10c. City, Town or Location<br>Columbia                                                                                                                                                          |                                                     |                                                                                      |                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                      |                                                                                                                                                                                                          |  |
| 10e. Street and Number<br>6150 Foreland Garth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                | 10f. Zip Code<br>21045                                                                                                                                                                           |                                                     | 10g. Citizen of What Country?<br>USA                                                 |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                     |                                                                                      |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                      |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Printer                                                                             |                                                     |                                                                                      |                                                      | 16b. Kind of Business/Industry<br>Printing Company                                                 |                                                      |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Henry A. Seiler, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Myrle L.M. Wack                                                                                                                             |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dearne M. Clements/Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5412 Thunder Hill Road, Columbia, Maryland 21045                                                |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Baltimore Washington Cr.                                                                                                                                                                                                      |                                                                                | Date<br>7/18/00                                                                                                                                                                                  |                                                     | 20c. Location - City or Town, State<br>Laurel, Maryland                              |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>B. M. Schlarman MD20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br>Witzke Funeral Homes, Inc.<br>5555 Twin Knolls Road, Columbia, MD 21045                                                                                      |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Sudden death<br>Due to (or as a consequence of):<br>b. Respiratory failure<br>Due to (or as a consequence of):<br>c. Aspiration Pneumonia<br>Due to (or as a consequence of):<br>d. Stroke<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes mellitus<br>Azotemia<br>Hypertension                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                           |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how injury occurred                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                               |                                                                                                  | 29b. Signature and title of certifier<br>Th. Jung MD                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                                                                                                  |                                                     | 29c. License number<br>D31927                                                        |                                                      | 29d. Date signed (Month, Day, Year)<br>July 16, 2000                                               |                                                      |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Ho-Lai Feng, MD Two Knoll North Dr. Columbia, MD 21045                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  | 32. Registrar's Signature<br>Benjamin S. Sparks                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                      |                                                      |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23391

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br>Samuel E. Snowden, III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 2. Date of Death<br>Month JULY Day 14 Year 2000                                                                                                                                                                                                                                     |  | 3. Time of Death<br>15:50 PM                                                                                                                          |  |
| 4a. Facility Name (If not institution, give street and number)<br>401 EAST 25th STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4b. City, Town, or Location of Death<br>BALTIMORE                                                                                                                                                                                                                                   |  | 4c. County of Death<br>N/A                                                                                                                            |  |
| 5. Social Security Number<br>219-30-3651                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                      |  | 7. Age (In yrs. last birthday)<br>67 Yrs.                                                                                                             |  |
| 8. Date of Birth (Month, Day, Year)<br>July 15, 1933                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                |  |                                                                                                                                                       |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. County<br>N/A                                                                                                                                                                                                                                                                  |  | 10c. City, Town or Location<br>Baltimore                                                                                                              |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10e. Street and Number<br>401 E. 25th Street, Apt. 7P                                                                                                                                                                                                                               |  | 10f. Zip Code<br>21218                                                                                                                                |  |
| 10g. Citizen of What Country?<br>USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                              |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Unk.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver                                                                                                                                                           |  | 16b. Kind of Business/Industry<br>Trucking Industry                                                                                                   |  |
| 17. Father's Name (First, Middle, Last)<br>Samuel E. Snowden, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertha Royster                                                                                                                                                                                                                 |  |                                                                                                                                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Betty Jackson / sister                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4021 Edmondson Avenue Baltimore, MD 21229                                                                                                                                          |  |                                                                                                                                                       |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                           |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.                                                                                                                                                                                     |  | 20c. Location - City or Town, State<br>Baltimore, MD                                                                                                  |  |
| 20d. Date<br>07/22/00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  |
| 21. Signature of Funeral Service Licensee<br>Dawn F. McDonald                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br>Cremation Society of MD, Inc.<br>299 Frederick Road Baltimore, MD 21228                                                                                                                                                                         |  |                                                                                                                                                       |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Hypertensive Cardiovascular Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                            |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                             |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                               |  |                                                                                                                                                       |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE                                                                                                                                                                                                                                                                                             |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |                                                                                                                                                       |  |
| 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                            |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                  |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                        |  |                                                                                                                                                       |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                             |  | 29b. Signature and title of certifier<br>Dennis J. Chute MD                                                                                                                                                                                                                         |  | 29c. License number<br>O.C.M.E.                                                                                                                       |  |
| 29d. Date signed (Month, Day, Year)<br>JULY 15, 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                               |  |                                                                                                                                                       |  |
| 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  |

Handwritten signature or initials

101 S 2 1000

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State of Maryland / Department of Health and Mental Hygiene

00 23392

amend itme 2a,b,c per fh G785 7/25/00 yg

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><b>Erin Scott</b>                                      |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>2000</b> |                                                                                                                                                                                               | 3. Time of Death<br><b>12:15 am</b>     |                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br><b>Atlantic General Hospital</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Berlin</b>                |                                                                                                                                                                                               | 4c. County of Death<br><b>Worcester</b> |                                                                                                |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br><b>077-80-6065</b>                                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>8</b>                           | If Under 1 Year<br>Months Days                                                                                                                                                                | If Under 24 Hrs.<br>Hours Min.          | 8. Date of Birth (Month, Day, Year)<br><b>11-05-1991</b>                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                        |                                                                                                                                                                                                                                                                                             | Usual Residence of Decedent                                          |                                                                                                                                                                                               |                                         |                                                                                                |
| 10a. State<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    | 10b. County<br><b>Otsego</b>                                                                                                                                                                                                                                                                |                                                                      | 10c. City, Town or Location<br><b>Unadilla</b>                                                                                                                                                |                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><b>13 Main Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    | 10f. Zip Code<br><b>13849</b>                                                                                                                                                                                                                                                               |                                                                      | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                         |                                         |                                                                                                |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3 Years</b><br>College (1-4 or 5+) -----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                                                                                                                                                                 |                                                                      | 16b. Kind of Business/Industry<br><b>Education</b>                                                                                                                                            |                                         |                                                                                                |
| 17. Father's Name (First, Middle, Last)<br><b>Kevin Scott</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eileen Pitsch</b>                                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kevin Scott (Father)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13 Main Street Otsego, New York 13849</b>                                                                                                                                               |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | 20b. Place of Disposition (Name of cemetery, crematorium or other place)<br><b>Chenango Valley Cem. Evergreen Hill Cemetery</b>                                                                                                                                                             |                                                                      | Date<br><b>7-27-00</b><br><b>7-25</b>                                                                                                                                                         |                                         | 20c. Location - City or Town, State<br><b>Earlville, N.Y. Unadilla, New York</b>               |
| 21. Signature of Funeral Service Licensee<br><b>J. Wayne Osterling</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    | 22. Name and Address of Facility<br><b>Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Ave. Catonsville, MD 21228</b>                                                                                                                                                               |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                                    | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                          |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    | 28a. Date of Injury (Month, Day, Year)<br><b>7/20/00</b>                                                                                                                                                                                                                                    |                                                                      | 28b. Time of Injury<br><b>2313 M</b>                                                                                                                                                          |                                         | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |
| 28d. Describe how injury occurred<br><b>Pedestrian struck by motor vehicle</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Street</b>                                                                                                                                                                                     |                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Ocean City, Md</b>                                                                                         |                                         |                                                                                                |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                       |                                                                                                    | 29b. Signature and title of certifier<br><b>J. Pestaner, M.D.</b>                                                                                                                                                                                                                           |                                                                      | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                        |                                         | 29d. Date signed (Month, Day, Year)<br><b>July 21, 2000</b>                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                    | 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                     |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |
| 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    | 33. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                               |                                         |                                                                                                |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23393

Amended item#1 per md g785 7-31-00 wj

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Drummond-Smith

2. Date of Death  
Month Day Year

JULY 20, 2000 2:15 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

227-62-9314

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.

FEB. 1, 1947

8. Date of Birth  
(Month, Day, Year)

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10a. Street and Number

911 LEADENHALL APT. 312

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

AFRO-AMERICAN

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEKEEPING

16b. Kind of Business/Industry

HOTEL

17. Father's Name (First, Middle, Last)

MATTHEW DRUMMOND

18. Mother's Name (First, Middle, Maiden Surname)

MACIE BUTTS

19a. Informant's Name/Relationship (Type, Print)

ORIS L. DRUMMOND (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4920 HOGANS LAKE PL. ANNANDALE, VA. 22003

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

KING MEMORIAL PK. JULY 25, 2000 BALTO, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bernadine B. Scruggs

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO. MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

RESPIRATORY FAILURE

a. Due to (or as a consequence of):

CHRONIC PULMONARY FIBROSIS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 MONTH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. M. M.

29c. License number

D 47945

29d. Date signed (Month, Day, Year)

July 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARIS ALEEM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23394

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mark Timothy Shamburg

2. Date of Death

July 24, 2000

Day Year

3. Time of Death

1:15 am

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

235-84-7434

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 29, 1956

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 Charles Plaza

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chef

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Carlton Eugene Shamburg

18. Mother's Name (First, Middle, Maiden Surname)

Frances May Vincent

19a. Informant's Name/Relationship (Type, Print)

Carlton E. Shamburg - father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2501 Pawnee St., Adelphi, MD 20783

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

7/25/00

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Steven H. Williams M00986

22. Name and Address of Facility

CAFA, Stephen D. Lohrmann, P.A.

8717 Green Pastures Drive, Towson, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis of Liver

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.A. Riley, MD

29c. License number

225205

29d. Date signed (Month, Day, Year)

July 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley, MD 16701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

Diana B. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-6000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23395

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                            |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>I. WILLIAM SCHIMMEL</b>                     |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 20, 2000</b> |                                                                                  | 3. Time of Death<br><b>11:15PM</b>                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>ROLAND PARK PLACE</b> |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                                                                  | 4c. County of Death<br><b>N/A</b>                                                              |                                                                                                                                                                                                  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>216-24-9886</b>                                            | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                   | 7. Age (In yrs. last birthday)<br><b>103</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                                                                                                              | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth (Month, Day, Year)<br><b>SEP. 15, 1896</b>                      |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>N.Y.</b>                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            | 10b. County<br><b>N/A</b>                                                                                                                                    |                                                   | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                                                                                                                                                             |                                                            |                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>4000 N. CHARLES STREET #1212</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                            |                                                                                                                                                              |                                                   | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                                                                                                               |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |                                                                                                |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWI</b> |                                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                               |                                                            |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                 |                                                                                            |                                                                                                                                                              |                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ATTORNEY</b>                                                                                                                                                                |                                                            |                                                                                  | 16b. Kind of Business/Industry<br><b>LAW</b>                                                   |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>DAVID SCHIMMEL</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                                                                                                                                                              |                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MINNIE APPEL</b>                                                                                                                                                                                                                    |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>BLANCHE SCHIMMEL / WIFE</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                                                                                                                                                              |                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4000 N. CHARLES ST. #1212 - BALTIMORE, MD 21218</b>                                                                                                                                     |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ANSHE EMUNAH (AITZ CHAIM)</b>                                                   |                                                   | Date<br><b>7.23.00</b>                                                                                                                                                                                                                                                                      |                                                            | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                      |                                                                                                |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br><i>Burton H. Levinson</i>                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                                                                                                                                                              |                                                   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                                                                                                                                                                 |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Congestive Heart failure</b><br>Due to (or as a consequence of):<br><b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>Hypertension</b>                                                |                                                                                            |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                  |                                                                                                | Approximate Interval Between Onset and Death<br><b>One Year</b><br><b>10 years</b><br><b>25 years</b>                                                                                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |                                                                                            |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                  |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                            |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                  |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                            |                                                                                                                                                              |                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                |                                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                       |                                                   | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                             |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                                                                                                                                                                |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                                                                                                                                                              |                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                            |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> , M.D.                                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                                                                                                                                                              |                                                   | 29c. License number<br><b>D 52016</b>                                                                                                                                                                                                                                                       |                                                            | 29d. Date signed (Month, Day, Year)<br><b>7/21/00</b>                            |                                                                                                |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>waiael Samara, 200 E. 22nd St. #650, Baltimore, MD 21218</b>                                                                                                                                                                                                                                                                      |                                                                                            |                                                                                                                                                              |                                                   |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                                                                                                                                                              |                                                   | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                             |                                                            |                                                                                  |                                                                                                |                                                                                                                                                                                                  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23396

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy E. Tidd

2. Date of Death

Month Day Year  
July 21 2000 8:03AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

089-34-2780

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 13, 1941

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 H Haspert Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Roland S. Williams

18. Mother's Name (First, Middle, Maiden Surname)

Esther Louise Squire

19a. Informant's Name/Relationship (Type, Print)

Mr. William J. Tidd (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 H Haspert Rd., Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

7/26/00

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pulmonary Embolus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

RD 203323

29d. Date signed (Month, Day, Year)

7/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sanju Varghese 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

TIDD, Nancy  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G786 8-22-00 WR.

Certificate of Death

Reg. No.

00 23397

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-858-8000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>CAROLINE ASHLEY THOMPSON</b>                                                                                                                                                           |                                                             |                                                                                                                                                   |                                                                                                                                                | 2. Date of Death<br>Month Day Year<br><b>JULY 20 2000</b>                                                                                                                                    |                                                                                             | 3. Time of Death<br><b>8:12 AM</b>                                                                                                                                                                                                                                                          |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>                                                                                                                        |                                                             |                                                                                                                                                   |                                                                                                                                                | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                     |                                                                                             | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                                                                                                           |                                                                                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>052-46-8383</b>                                                                                                                                                                                       |                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br><b>31</b> Yrs.                                                                                               | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                                              | 8. Date of Birth<br>(Month, Day, Year)<br><b>JULY 31, 1968</b>                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>N.Y.</b>                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                           |                                                             |                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                       | 10b. County<br><b>N/A</b>                                   |                                                                                                                                                   | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                |                                                                                                                                                                                              |                                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                              |                                                                                      |  |
| 10e. Street and Number<br><b>3032 GUILFORD AVE</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                   | 10f. Zip Code<br><b>21218</b>                                                                                                                  |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>U.S.A</b>                                               |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                       |                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                     |                                                                                      |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGER</b>                 |                                                                                                                                                                                              | 16b. Kind of Business/Industry<br><b>STORE FIRM</b>                                         |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 17. Father's Name (First, Middle, Last)<br><b>William G. Thompson</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KAREN D. UNKNOWN</b>                                                                   |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William G. Thompson</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1049 LYN RD. BOLLING GREEN OHIO, 43402</b> |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                                                                                                                                                                       |                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>                                              |                                                                                                                                                | Date<br><b>7/24/00</b>                                                                                                                                                                       |                                                                                             | 20c. Location - City or Town, State<br><b>BALTO. MD.</b>                                                                                                                                                                                                                                    |                                                                                      |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                   | 22. Name and Address of Facility<br><b>HATLEY MILLER Funeral Home cHHD.<br/>7527 HARFORD RD. BALTO. MD 21234</b>                               |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>HEAD INJURIES</b> |                                                             |                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             | Approximate Interval Between Onset and Death                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Due to (or as a consequence of):</b><br>a. _____<br>b. _____<br>c. _____<br>d. _____            |                                                             |                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                                                              |                                                                                             | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                      |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                       | 28a. Date of Injury<br>(Month, Day, Year)<br><b>7-20-00</b> |                                                                                                                                                   | 28b. Time of Injury<br><b>UNKNOWN</b>                                                                                                          |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                                                                             | 28d. Describe how injury occurred<br><b>SUBJECT FELL DOWN STEPS OUTSIDE HER HOME</b> |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                       | 29b. Signature and title of certifier<br>                   |                                                                                                                                                   | 29c. License number<br><b>O.C.M.E.</b>                                                                                                         |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>JULY 20, 2000</b>                                 |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                       | 32. Registrar's Signature<br>                               |                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                      |  |



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CRAIG STEVEN TALLEY

State of Maryland / Department of Health and Mental Hygiene

ASP AMEND ITEMS: #23 PART I, 27 PER MEO 6786 8 19 00 WR.

Reg. No.

00 23398

Certificate of Death

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>CRAIG S. TALLEY</b>                                |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>JULY 19 2000</b> |                                                                                             | 3. Time of Death<br><b>2310</b>                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>ESSEX</b>      |                                                                                             | 4c. County of Death<br><b>BALTIMORE</b>                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>215-74-6384</b>                                                   |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.          |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>MAY 24, 1961</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                             |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                              | 10b. County<br><b>BALTIMORE</b>                           |                                                                                             | 10c. City, Town or Location<br><b>Parkville</b>            |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   | 10e. Street and Number<br><b>9A MOPEC. CT.</b>                                                                                                                                                                                                                                              |                                                                            | 10f. Zip Code<br><b>21236</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |                                                            |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |                                                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (14-18) <b>4 yrs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warehouse</b>                                                                                                                                                               |                                                                            | 16b. Kind of Business/Industry<br><b>SUNPAPER .COMP.</b>                                                                                                                                     |                                                           |                                                                                             |                                                            |  |
| 17. Father's Name (First, Middle, Last)<br><b>EARL-LEE TALLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sophia SMITH</b>                                                                                                                     |                                                           |                                                                                             |                                                            |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CHRISTINA TALLEY (wife)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9A MOPEC. CT. Balto. MD 21236</b>                                                        |                                                           |                                                                                             |                                                            |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OAKLAWN cemetery</b>                                                                                                                                                                                           |                                                                            | 20c. Location - City or Town, State<br><b>Balto. MD.</b>                                                                                                                                     |                                                           | 20d. Date<br><b>7/24/00</b>                                                                 |                                                            |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>HARTLEY MILLER Funeral Home CHD<br/>7527 HARFORD RD. Balto. MD 21234</b>                                                                              |                                                           |                                                                                             |                                                            |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                            |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                           |                                                                                             |                                                            |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            | 29c. License number<br><b>O.C.M.E</b>                                                                                                                                                        |                                                           | 29d. Date signed (Month, Day, Year)<br><b>JULY 20, 2000</b>                                 |                                                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE MILLER 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                            |  |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23399

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  |                                                                   |                                                                                                                                         |                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>NOR LEE WILLIAMS</b>                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  | 2. Date of Death<br>Month <b>7</b> Day <b>23</b> Year <b>2000</b> |                                                                                                                                         | 3. Time of Death<br><b>5:20 AM</b>                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL BALTIMORE</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>NA</b>                 |                                                                                                                                         | 4c. County of Death<br><b>NA</b>                       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>219-10-1786</b>                                                         |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                  |                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br><b>12-01-20</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                   |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                                  | 10b. County<br><b>NA</b>                                          |                                                                                                                                         | 10c. City, Town or Location<br><b>Baltimore</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | 10e. Street and Number<br><b>1900 N. Wolfe Street</b>                                                                                                                                                                                                                                       |                                                                            | 10f. Zip Code<br><b>21213</b>                                                                                                                                                                    |                                                                   | 10g. Citizen of What Country?<br><b>USA</b>                                                                                             |                                                        |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                         |                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |                                                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                 |                                                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>High Sch Grade</b> College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fork Lift Operator</b>                                                                                                                                                      |                                                                            | 16b. Kind of Business/Industry<br><b>General Refactory</b>                                                                                                                                       |                                                                   |                                                                                                                                         |                                                        |  |
| 17. Father's Name (First, Middle, Last)<br><b>Leon Williams</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Chase</b>                                                                                                                        |                                                                   |                                                                                                                                         |                                                        |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rushie Williams</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21213 1900 N. Wolfe Street Baltimore, Maryland</b>                                              |                                                                   |                                                                                                                                         |                                                        |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                  |                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Pk. Cem.</b>                                                                                                                                                                                      |                                                                            | 20c. Location - City or Town, State<br><b>07-29-2000 Arbutus, MD</b>                                                                                                                             |                                                                   |                                                                                                                                         |                                                        |  |
| 21. Signature of Funeral Service Licensee<br><b>gabriele cork</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>                                                                                          |                                                                   |                                                                                                                                         |                                                        |  |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>SEPTICEMIA</b><br>Due to (or as a consequence of):<br><b>END STAGE RENAL DISEASE</b><br>Due to (or as a consequence of):<br><b>HYPERTENSION</b><br>Due to (or as a consequence of):<br><b>DIABETES MELLITUS</b> |                                                                                                         | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                  |                                                                   |                                                                                                                                         |                                                        |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                   |                                                                                                                                         |                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                        |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                                  |                                                                   |                                                                                                                                         |                                                        |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                             |                                                                                                         | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |                                                                   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                             |                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                           |                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                            |                                                        |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                              |                                                                                                         | 29b. Signature and title of certifier<br><b>Rosita R. Cruz M.D.</b>                                                                                                                                                                                                                         |                                                                            | 29c. License number<br><b>00030355</b>                                                                                                                                                           |                                                                   | 29d. Date signed (Month, Day, Year)<br><b>July 23, 2000</b>                                                                             |                                                        |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROSITA R. CRUZ M.D. - BON SECOURS HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  |                                                                   |                                                                                                                                         |                                                        |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  |                                                                   |                                                                                                                                         |                                                        |  |





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State of Maryland / Department of Health and Mental Hygiene

Augusta Wallace

## Certificate of Death

Reg. No.

00 23400

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Augusta Antonetta Wallace                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>JULY 24, 2000                                                                                                                                                      |                          | 3. Time of Death<br>1:40pm                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Augsburg Lutheran Home                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Lochearn                                                                                                                                                         |                          | 4c. County of Death<br>Baltimore                                                                                                                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>577-26-7157                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>91 Yrs.                                                                                                                                                                |                          | 8. Date of Birth (Month, Day, Year)<br>MARCH 29, 1909                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. Birthplace (State or Foreign Country)<br>England                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10a. State<br>Maryland                                                         |                                                                                                                                                                                                                                                                                                         | 10b. County<br>Baltimore                                                                                                                                                                                 |                          | 10c. City, Town or Location<br>Owings Mills                                                                                                           |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 10e. Street and Number<br>7 Village Gate Court                                                                                                                                                           |                          | 10f. Zip Code<br>21117                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10g. Citizen of What Country?<br>USA                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                    |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                          | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 16b. Kind of Business/Industry<br>Own Home                                                                                                                                                               |                          |                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>George James                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br>Clarissa Staiger                                                                                                                                    |                          |                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Victoria J. Wallace/daughter                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7 Village Gate Court Owings Mills, MD 21117                                                             |                          |                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                      |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.                                                                                                          |                          | 20c. Location - City or Town, State<br>Baltimore, MD                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Thomas Gregor                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, MD 21228                                                                                        |                          |                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. acute myocardial infarction<br>Due to (or as a consequence of):<br>b. coronary artery disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |                                                                                |                                                                                                                                                                                                                                                                                                         | Approximate Interval Between Onset and Death<br>1 hour<br>years                                                                                                                                          |                          |                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |                                                                                                                                                                                                                                                                                                         | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                          |                                                                                                                                                       |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                          | 28b. Time of Injury<br>M |                                                                                                                                                       |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |
| 29c. License number<br>D37573                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                | 29d. Date signed (Month, Day, Year)<br>July 24, 2000                                                                                                                                                                                                                                                    |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Jef Zibell MD 7220 Park Heights Ave Baltimore MD 21208                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                | 31. Date filed (Month, Day, Year)<br>JUL 25 2000                                                                                                                                                                                                                                                        |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |
| 32. Registrar's Signature<br>Sparks                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                          |                          |                                                                                                                                                       |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23401

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Dorothy Zebraski

2. Date of Death

Month Day Year  
July 23 2000

3. Time of Death

9:40 A.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-22-1624

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

8. Date of Birth

Month Day Year  
Oct. 23, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

823 Loalan Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8 Years

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Anthony Fialkowski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Mazor

19a. Informant's Name/Relationship (Type, Print)

Donna M. Kurtz (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7851 North Cove Road Edgemere, Maryland 21219

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Ht of Jesus Cem. 7/26/2000

Date

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Lung Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

RD 203320

29d. Date signed (Month, Day, Year)

7/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanju Varghese 9000 Franklin Square Drive Baltimore MD 21227

31. Date filed (Month, Day, Year)

JUL 25 2000

32. Registrar's Signature

*[Signature]*

State  
Registrar

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23402

|                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Anne C. Adams</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                     |                                               | 2. Date of Death<br>Month Day Year<br><b>July 10, 2000</b>                                                                                                                                   |                                                                                                | 3. Time of Death<br><b>1:25pm</b>                                                                                                                                                                                                                                                           |                                                                 |
|                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care Potomac</b>                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                     |                                               | 4b. City, Town, or Location of Death<br><b>Potomac</b>                                                                                                                                       |                                                                                                | 4c. County of Death<br><b>Montgomery</b>                                                                                                                                                                                                                                                    |                                                                 |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>366-56-5287</b>                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                                                                                                    | If Under 1 Year<br>Months Days                | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 4, 1915</b>                                     |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Bessemer, MI</b> |
|                                                         | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
| To Be Completed by Funeral Director                     | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                             | 10b. County<br><b>Montgomery</b>                                           | 10c. City, Town or Location<br><b>Potomac</b>                                                                                                       |                                               |                                                                                                                                                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                                                                             |                                                                 |
|                                                         | 10e. Street and Number<br><b>10714 Potomac Tennis Lane</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 10f. Zip Code<br><b>20854</b>                                                                                                                       |                                               | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                        |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
|                                                         | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                     |                                                                 |
|                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                              |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Wife</b>                      |                                               | 16b. Kind of Business/Industry<br><b>Own Home</b>                                                                                                                                            |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
| To Be Completed by Physician/Medical Examiner           | 17. Father's Name (First, Middle, Last)<br><b>Albino Mascotti</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                     |                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angeline Weidman</b>                                                                                                                 |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
|                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria Anne Fenton/Daughter</b>                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                     |                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5221 Wyoming Road Bethesda, MD 20816</b>                                                 |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
|                                                         | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory, Inc</b>                                          |                                               | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>                                                                                                                           |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
|                                                         | 21. Signature of Funeral Service Licensee<br><b>Laura C. Hardesty</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 22. Name and Address of Facility<br><b>Rapp Funeral and Cremation Services<br/>Stephen D. Lohrmann PA<br/>933 Gist Ave. Silver Spring, MD 20910</b> |                                               |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
| Physician<br>/Medical<br>Examiner                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Alzheimer's Disease</b>                                                                                                                                                                                   |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                | Approximate Interval Between Onset and Death<br><b>years</b>                                                                                                                                                                                                                                |                                                                 |
|                                                         | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>UROSEPSIS</b>                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
|                                                         | 23c. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
|                                                         | 23d. Enter Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
| To Be Completed by Physician/Medical Examiner           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                 |
|                                                         | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                              |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                               |                                               | 28b. Time of Injury<br>M                                                                                                                                                                     |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |                                                                 |
|                                                         | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                              |                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
|                                                         | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
| State<br>Registrar                                      | 29b. Signature and title of certifier<br><b>Michael J. Grady</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                     |                                               | 29c. License number<br><b>D-0038781</b>                                                                                                                                                      |                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>7/10/00</b>                                                                                                                                                                                                                                       |                                                                 |
|                                                         | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael J. Grady<br/>4910 Massachusetts Ave NW #210 Washington, DC 20016-4300</b>                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                     |                                               |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b> |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                     | 32. Registrar's Signature<br><b>B. Sparks</b> |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                 |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 23403

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                             |  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>RICKEY LEO ADDISON</b>                                                                                                                                                                                                                       |  |                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 5, 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 3. Time of Death<br><b>0050</b>                                                             |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>                                                                                                                                                                                     |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4c. County of Death<br><b>MONTGOMERY</b>                                                    |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-64-9826</b>                                                                                                                                                                                                                                             |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 7, 1954</b>                                 |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                 |  | 10a. State<br><b>MD</b>                                                                                                                           |  | 10b. County<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10c. City, Town or Location<br><b>Rockville</b>                                             |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                              |  | 10e. Street and Number<br><b>70 Moore Drive</b>                                                                                                   |  | 10f. Zip Code<br><b>20850</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |  |
|                                               | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                              |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b>                                                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>General Laborer</b>               |  | 16b. Kind of Business/Industry<br><b>Construction</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                             |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>Leroy Addison</b>                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Cooper</b>                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Louise Addison (Mother)</b>                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>70 Moore Drive, Rockville, MD 20850</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                             |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                       |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Norbeck Mem. Park</b>                                                |  | 20c. Location - City or Town, State<br><b>7/13/00 Olney, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                             |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>                                                                                                                                                                                               |  |                                                                                                                                                   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Ventricular fibrillation</b><br>Due to (or as a consequence of):<br><b>Cardiomyopathy</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Renal failure</b> |  |                                                                                             |  |
|                                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |  |                                                                                                                                                   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |  |                                                                                                                                                   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                             |  |
|                                               | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                             |  |                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                                                                                                   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                           |  |                                                                                             |  |
|                                               | 29b. Signature and title of certifier<br><i>[Signature]</i> MD                                                                                                                                                                                                                              |  |                                                                                                                                                   |  | 29c. License number<br><b>29453</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 29d. Date signed (Month, Day, Year)<br><b>July 6, 2000</b>                                  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ALAN S. CHAMBERS 15225 Shady Grove Rd Rockville MD 20850</b>                                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                             |  |
|                                               | 31. Data filed (Month, Day, Year)<br><b>JUL 13 2000</b>                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                             |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amend #20a, 7/13/2000, BMW, Montg. Co.

00 23404

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE MAE ALLEN

2. Date of Death

JULY 9, 2000

3. Time of Death

9:45 AM

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF BETHESDA

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

217-30-0343

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

DEC. 10 1909

9. Birthplace (State or Foreign Country)

S. CAROLINA

Usual Residence of Decedent

10e. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6506 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

ROSA RAIFORD

19a. Informant's Name/Relationship (Type, Print)

JOSEPH ALLEN ( SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 TEA ROSE CT. GAITHERSBURG, MD. 20879

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of Facility or other place)

GEORGETOWN MEDICAL

Date

7/10/00

20c. Location - City or Town, State

WASHINGTON D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

AUSTIN ROYSTER FUNERAL HOME  
3821 14TH ST. N.W. WASHINGTON D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weekb.   
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular AccidentHypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

020516

29d. Date signed (Month, Day, Year)

July 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Schuman 9410 Old Georgetown Rd Bethesda, MD 20814

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



jhm  
CHARLES D  
ANDERSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23405

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br>Charles David Anderson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br>JULY 04, 2000                                                                                                                                               |  | 3. Time of Death<br>15:05 PM                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br>ROUTE 301                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                   |  | 4b. City, Town, or Location of Death                                                                                                                                                              |  | 4c. County of Death<br>CHARLES                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br>212-80-2196                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                    |  | 7. Age (In yrs. last birthday)<br>38 Yrs.                                                                                                                                                         |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 5, 1962                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10a. State<br>VA                                                                                                                                                                                                                                                                                                  |  | 10b. County<br>Westmoreland                                                                                                                                                                       |  | 10c. City, Town or Location<br>Montross                                                         |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10e. Street and Number<br>P.O. Box 301                                                                                                                                                                                                                                                                            |  | 10f. Zip Code<br>22520                                                                                                                                                                            |  | 10g. Citizen of What Country?<br>USA                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                             |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpenter                                                                                                                                                                                            |  | 16b. Kind of Business/Industry<br>Self Employed                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 17. Father's Name (First, Middle, Last)<br>Max Anderson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Cynthia Inez Fowler                                                                                                                          |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 19a. Informant's Name/Relationship (Type, Print)<br>Cayce Harrison - Friend                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 98 Montross, VA 22520                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory                                                                                                                                                                                                                  |  | 20c. Location - City or Town, State<br>Alexandria, Virginia                                                                                                                                       |  | 20d. Date<br>7/6/00                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Metropolitan Funeral Service, Inc.<br>5517 Vine Street Alexandria, VA 22310                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Multiple Injuries</i><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)<br>street |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                  |  | 28a. Date of Injury (Month, Day, Year)<br>7-4-00                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>1458 PM                                                                                                                                                                    |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 28d. Describe how injury occurred<br>motorcycle accident                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Bel Air Highway                                                                                                                                                                                                         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Bel Air, Md                                                                                                       |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                   |  | 29c. License number<br>OCME                                                                                                                                                                       |  | 29d. Date signed (Month, Day, Year)<br>JULY 05, 2000                                            |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis Chute 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31. Date filed (Month, Day, Year)<br>JUL 12 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                 |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23406

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Virginia J. Angus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                                  | 2. Date of Death<br>Month Day Year<br><b>July 8, 2000</b>                                                                                                                                        |                                | 3. Time of Death<br><b>7:35PM</b>                                                                                                                                                                        |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>3316 Estelle Terrace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                                  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>                                                                                                                                     |                                | 4c. County of Death<br><b>Montgomery</b>                                                                                                                                                                 |  |
| 5. Social Security Number<br><b>232-26-3647</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>May 18, 1921</b>                                                                                                                                               |  |
| 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                          |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. County<br><b>Montgomery</b>                                                                                                                                                                                                                                                                        |                                                  | 10c. City, Town or Location<br><b>Silver Spring</b>                                                                                                                                              |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |  |
| 10e. Street and Number<br><b>3316 Estelle Terrace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |                                                  | 10f. Zip Code<br><b>20906</b>                                                                                                                                                                    |                                | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                                    |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Analyst</b>                                                                      |                                | 16b. Kind of Business/Industry<br><b>Federal Government</b>                                                                                                                                              |  |
| 17. Father's Name (First, Middle, Last)<br><b>Otis Jennings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nora Dressler</b>                                                                                                                        |                                |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Earl H. Angus/Husband</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3316 Estelle Terrace Silver Spring, MD 20906</b>                                             |                                |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>                                                                                                                                                                                                 |                                                  | Date<br><b>7/12/00</b>                                                                                                                                                                           |                                | 20c. Location - City or Town, State<br><b>Rockville, MD</b>                                                                                                                                              |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                                  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.<br/>11800 New Hampshire Ave SilverSpring, MD 20904</b>                                                                   |                                |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br>b. <b>Ischemic cardiomyopathy</b><br>Due to (or as a consequence of):<br>c. <b>Recurrent hyponatremia</b><br>Due to (or as a consequence of):<br>d. |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                  |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                  | 28b. Time of Injury<br>M                                                                                                                                                                         |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                           |                                |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                          |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                                  | 29c. License number<br><b>D47928</b>                                                                                                                                                             |                                | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                                                                                                                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>L. Bahadore, M.D. 10301 Georgia Avenue, #304, Silver Spring, Maryland 20902</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. Registrar's Signature<br>                                                                                                                                                                                       |                                                  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                          |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23407

|                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                           |                                                                                                           |                                                             |                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>MONICA ELIZABETH AUTRIDGE</b>                            |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 9, 2000</b> |                                                                                                           | 3. Time of Death<br><b>11:00 AM</b>                         |                                                                                                                                             |  |
|                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>  |                                                                                                           | 4c. County of Death<br><b>MONTGOMERY</b>                    |                                                                                                                                             |  |
| Funeral<br>Director                                                                                                                                                                    | 5. Social Security Number<br><b>209-52-8062</b>                                                         |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>37</b> Yrs.          |                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 31, 1963</b> |                                                                                                                                             |  |
|                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><b>West Indies</b>                                          |                                                                                                                                                                                                                                                                                                         | 10a. State<br><b>MD</b>                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10b. County<br><b>Montgomery</b>                          |                                                                                                           | 10c. City, Town or Location<br><b>Germantown</b>            |                                                                                                                                             |  |
| Usual Residence of Decedent                                                                                                                                                            |                                                                                                         | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                      |                                                                                | 10e. Street and Number<br><b>12015 Panthers Ridge Dr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                           | 10f. Zip Code<br><b>20876</b>                                                                             |                                                             | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                              |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                         |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                   |                                                             |                                                                                                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4 yrs</b>                                                     |                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Recreational Therapist</b>                                                                                                                                                              |                                                                                | 16b. Kind of Business/Industry<br><b>Springbrook Nursing &amp; Rehab Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                           | 17. Father's Name (First, Middle, Last)<br><b>Lionel Cecil Browne</b>                                     |                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Earla Sargeant</b>                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elwood Autridge (Husband)</b>                                                                                                   |                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12015 Panthers Ridge Dr., Germantown, MD 20876</b>                                                                                                                                                  |                                                                                | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                             |                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cem.</b>      |                                                             | 20c. Location - City or Town, State<br><b>7/15/00 Silver Spring, MD</b>                                                                     |  |
| 21. Signature of Funeral Service Licensee<br>                                                        |                                                                                                         | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>                                                                                                                                                                                                           |                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>Brain Death</b><br>Due to (or as a consequence of):<br>b. <b>Intracerebral Hemorrhage</b><br>Due to (or as a consequence of):<br>c. <b>Cerebral Aneurysm</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                           | Approximate Interval Between Onset and Death                                                              |                                                             |                                                                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                 |                                                                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                    |                                                           | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                  |                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                      |                                                           | 28a. Date of Injury (Month, Day, Year)<br><b>July 9, 2000</b>                                             |                                                             | 28b. Time of Injury<br><b>M</b>                                                                                                             |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                   |                                                                                                         | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                              |                                                             |                                                                                                                                             |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner                                                                                              |                                                                                                         | 29b. Signature and title of certifier<br>                                                                                                                                                                            |                                                                                | 29c. License number<br><b>D-0055687</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                           | 29d. Date signed (Month, Day, Year)<br><b>July, 09, 2000</b>                                              |                                                             |                                                                                                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GUNWANT HALLIK, MD 198 THOMAS JOHNSON DR. FREDERICK, MD 21702</b>                           |                                                                                                         | 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                 |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                           |                                                                                                           |                                                             |                                                                                                                                             |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 23408

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>LOIS P. AUGUSTINOS</b>                                      |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>JULY</b> Day <b>11</b> Year <b>2000</b>                                                                           |                                                                                                                                                                                              | 3. Time of Death<br><b>19:30</b>                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital Center</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Clinton</b>                                                                                         |                                                                                                                                                                                              | 4c. County of Death<br><b>Prince George's</b>                                                                                                                                                    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>005-20-8489</b>                                                            | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                               | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>April 19 1920</b>                                                |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Maine</b>                                                                                       |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            | 10b. County<br><b>Prince George's</b>                                                                                                                                                                                                                                                       |                                                                                                                                                | 10c. City, Town or Location<br><b>Upper Marlboro</b>                                                                                                                                         |                                                                                                                                                                                                  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>12101 North Marlton Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                            |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>20772</b>                                                                                                                  |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                            |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                  |                                                                                                                                                                                              | 16b. Kind of Business/Industry<br><b>Own Home</b>                                                                                                                                                |
| 17. Father's Name (First, Middle, Last)<br><b>Wilfred Pearson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                            |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Pearson</b>                                                                      |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Avis Ames Styles (Daughter)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                            |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16 Kings Wharf Place Waldorf, MD 20602</b> |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oakdale Cemetery</b>                                                                                                                                                                                           |                                                                                                                                                | 20c. Location - City or Town, State<br><b>Sanford Maine</b>                                                                                                                                  |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br> <b>MO0173</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            | 22. Name and Address of Facility<br><b>Eberwein Funeral Services</b><br><b>4433 White Pls. La. White Pls., MD 20695</b>                                                                                                                                                                     |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. VENTRICULAR TACHYCARDIA</b><br>Due to (or as a consequence of):<br><b>b. RENAL FAILURE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              | Approximate Interval Between Onset and Death<br><b>5 MINS.</b>                                                                                                                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATRIAL FIBRILLATION</b><br><b>METABOLIC ACIDOSIS</b><br><b>CONGESTIVE HEART FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                                                                                                                                                  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                    |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                            | 29c. License number<br><b>D 28281</b>                                                                                                                                                                                                                                                       |                                                                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>JULY 12, 2000</b>                                                                                                                                  |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Belgers Clinton, Md 20735</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                                                                                                |                                                                                                                                                                                              |                                                                                                                                                                                                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23409

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br>Mary Augusta Archer                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br>July 7, 2000 |                                                                                      | 3. Time of Death<br>6:15 P.M.                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br>Annapolis  |                                                                                      | 4c. County of Death<br>Anne Arundel                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br>216-18-5373                                                      |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>Yrs. 75          |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Nov. 20, 1924 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br>Maryland                                          |                                                                                                                                                                                                                                                                                                         | 10a. State<br>Maryland                                                         |                                                                                                                                                                                                          | 10b. County<br>Anne Arundel                        |                                                                                      | 10c. City, Town or Location<br>Edgewater             |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               | 10e. Street and Number<br>1732 Ridgely Road                                                                                                                                                                                                                                                             |                                                                                | 10f. Zip Code<br>21037                                                                                                                                                                                   |                                                    | 10g. Citizen of What Country?<br>USA                                                 |                                                      |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                  |                                                                                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |                                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th<br>College (1-4 or 5+) College (1-4 or 5+)                                                                                                                                                                                                                                                                                           |                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                  |                                                                                | 16b. Kind of Business/Industry<br>Home                                                                                                                                                                   |                                                    |                                                                                      |                                                      |  |
| 17. Father's Name (First, Middle, Last)<br>Herman Parkinson                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lena Whittington                                                                                                                                    |                                                    |                                                                                      |                                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Whitman J. Archer/ Husband                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1732 Ridgely Road Edgewater, Maryland 21037                                                             |                                                    |                                                                                      |                                                      |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                         |                                                                                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory                                                                                                                                                                                                        |                                                                                | 20c. Location - City or Town, State<br>Alexandria, Virginia                                                                                                                                              |                                                    | 20d. Date<br>7-9-00                                                                  |                                                      |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>2973 Solomons Island Rd. Edgewater, MD 21037                                                                                         |                                                    |                                                                                      |                                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                               | a. Pneumonia<br>Due to (or as a consequence of):<br>b. Respiratory Failure<br>Due to (or as a consequence of):<br>c. Myocardial Infarction<br>Due to (or as a consequence of):<br>d. Lung Cancer                                                                                                        |                                                                                | Approximate Interval Between Onset and Death<br>5<br>5<br>5                                                                                                                                              |                                                    |                                                                                      |                                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Emphysema                                                                                                                                                                                                                                                                                                     |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                    |                                                                                      |                                                      |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                   |                                                                                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                  |                                                                                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                                 |                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                             |                                                    |                                                                                      |                                                      |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.               |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 29c. License number<br>D41216                                                                                                                                                                            |                                                    | 29d. Date signed (Month, Day, Year)<br>July 7, 2000                                  |                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis M. Hall, M.D. 900 Bestgate Rd. #301 Annapolis, Md                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |  |
| 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                                                                                                          |                                                    |                                                                                      |                                                      |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 23410

Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                    |  |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GLADYS ANITA AUSHERMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>June 29 2000</b>                                                                                                                                                                                                                                               |                                                                         | 3. Time of Death<br><b>8:47 a.m.</b>                                                               |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>6185 Sandy Point Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>                                                                                                                                                                                                                                         |                                                                         | 4c. County of Death<br><b>Calvert</b>                                                              |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220 82 9999</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.                                                                                                                                                  |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 23, 1922</b>                                                                                                                                                                                                                                             |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                        |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                    |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. County<br><b>Calvert</b>                                                                                                                         |  | 10c. City, Town or Location<br><b>Prince Frederick</b>                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |                                                                         | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                               | 10e. Street and Number<br><b>6185 Sandy Point Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |  | 10f. Zip Code<br><b>20678</b>                                                                                                                                                                     |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                             |                                                                         |                                                                                                    |  |
|                                               | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                                                                                                                                                                                                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |                                                                                                    |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>none</b>                                                                          |  |                                                                                                                                                                                                                                                                                                         | 16b. Kind of Business/Industry                                          |                                                                                                    |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>Lester Franklin Ausherman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nettie Bertha Strube</b>                                                                                                                                                                                                                        |                                                                         |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty M. Hutchison</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 129, Riva, MD 21140</b>                                                                                                                                                                    |                                                                         |                                                                                                    |  |
|                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                                                                           |  | Date<br><b>6-30-00</b>                                                                                                                                                                                                                                                                                  |                                                                         | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>                                       |  |
|                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A., Owings, MD 20736</b>                                                                                                                                                                                                                  |                                                                         |                                                                                                    |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PRESUMPTIVE MALIGNANCY - PRIMARY UNKNOWN 6-7 MONTH</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                    |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>LIFELONG PROFOUND MENTAL RETARDATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                    |  |
| State Registrar                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                         |                                                                                                    |  |
|                                               | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                    |                                                                         | 28d. Describe how injury occurred                                                                  |  |
|                                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                 |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 29b. Signature and title of certifier<br>                                                                                                                                                                            |                                                                         | 29c. License number<br><b>12658</b>                                                                |  |
|                                               | 29d. Date signed (Month, Day, Year)<br><b>JUNE 29 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN H. WIGGEL MD - PRINCE FREDERICK, MD - 20678</b>                                                                                                                                                         |                                                                         |                                                                                                    |  |
|                                               | 31. Date filed (Month, Day, Year)<br><b>JUN 30 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |  | 32. Registrar's Signature<br>                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 23411

Amended Item #7 per FHG785 7/25/2000 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lester

C.

Annack

2. Date of Death

Month Day Year  
June 26, 2000

3. Time of Death

5:50am

4a. Facility Name (If not institution, give street and number)

Northampton Manor Nursing Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

323-18-7012

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 ~~81~~ Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jul 11, 1922

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 East 16th Street

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No World  
If Yes, Give Year or Dates: War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Philip

Annack

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle

Peterson

19a. Informant's Name/Relationship (Type, Print)

Virginia R. Farney/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9915 Pinetree Road, Woodsboro, Maryland 21798

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Hill Cemetery Jun 29, 2000 Glasgow, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]* M00706

22. Name and Address of Facility

Keeney &amp; Basford P.A. Funeral Home

106 East Church St, Frederick, Maryland 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *pneumonia*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Chronic obstructive pulmonary disease*  
Due to (or as a consequence of):

20 years

c. *Diabetes*  
Due to (or as a consequence of):

40 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Congestive Heart Failure**Colon Arteriovenous malformations*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D41994

29d. Date signed (Month, Day, Year)

June 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gerard A. Del Grippo, Jr, M.D., 15 East Frederick Street, Walkersville, MD 21793

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

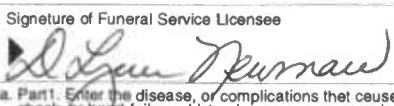

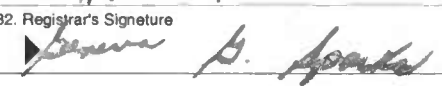
State of Maryland / Department of Health and Mental Hygiene

00 23412

amend item 8 per fh G786 8/7/00 yg

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>SARA ANN ALEXANDER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 | 2. Date of Death<br>Month Day Year<br><b>JULY 2, 2000</b>                                                                                                                                        |                                                                                                                                                                                                                                                                                                         | 3. Time of Death<br><b>6:35AM</b>                                       |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>GOODWILL MENNONITE HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 | 4b. City, Town, or Location of Death<br><b>GRANTSVILLE</b>                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4c. County of Death<br><b>GARRETT</b>                                   |                                                                                                                                                                                                          |
| Funeral<br>Director                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>217-28-7663</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                 | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br><b>1903 July 6, 2000</b>         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                  | 10a. State<br><b>MD</b>                                                                                                                               |                                 | 10b. County<br><b>Garrett</b>                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br><b>Accident</b>                          |                                                                                                                                                                                                          |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                    | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                  | 10e. Street and Number<br><b>301 S. Main St.</b>                                                                                                      |                                 | 10f. Zip Code<br><b>21520</b>                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 10g. Citizen of What Country?<br><b>USA</b>                             |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                                                                                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7 th</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Counter</b>                           |                                 | 16b. Kind of Business/Industry<br><b>Telephone Co..</b>                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 17. Father's Name (First, Middle, Last)<br><b>Williard Frickey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Klotz</b>                                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert L. Alexander/son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>419 Camp Riamo Road, Farmington, PA 15437</b>                                                |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bear Creek Cem., July 5, 2000</b>                                        |                                 | 20c. Location - City or Town, State<br><b>Accident, MD</b>                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 | 22. Name and Address of Facility<br><b>Newman Funeral Homes, P.A., PO Box 275<br/>179 Miller St., Grantsville, MD 21536</b>                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | Approximate Interval Between Onset and Death<br><b>1 Year</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hemiplegia, Aphasia and Dysphagia due to cerebrovascular disease and old stroke</b> |                                                                                                                                                       |                                 |                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                               |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                                         |                                                                                                                                                                                                          |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                         |                                                                                                                                                                                                          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28a. Date of Injury (Month, Day, Year)<br><b>July 5, 2000</b>                                                                                                                                                    |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b> |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                    |                                                                         |                                                                                                                                                                                                          |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                         |                                                                                                                                                                                                          |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                          |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 29b. Signature and title of certifier<br> <b>Walter K. Naumann, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 | 29c. License number<br><b>D0025759</b>                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 29d. Date signed (Month, Day, Year)<br><b>JULY 2, 2000</b>              |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Walter K. Naumann, M.D. PO Box 247, Accident MD 21520</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 |                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                        | 31. Date filed (Month, Day, Year)<br><b>JUL - 3 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                  |                                                                                                                                                       |                                 | 32. Registrar's Signature<br>                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                         |                                                                                                                                                                                                          |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the President's annual message to Congress.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1863. It contains a detailed account of the financial condition of the United States at that time.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1863. It contains a detailed account of the land and mineral resources of the United States.

4. The fourth part of the document is a report from the Secretary of the War, dated January 1, 1863. It contains a detailed account of the military operations of the United States during the year.

5. The fifth part of the document is a report from the Secretary of the Navy, dated January 1, 1863. It contains a detailed account of the naval operations of the United States during the year.

6. The sixth part of the document is a report from the Secretary of the State, dated January 1, 1863. It contains a detailed account of the foreign relations of the United States during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23413

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rollin Meredith Bell, Jr.

2. Date of Death

Month Day Year  
July 7, 2000

3. Time of Death

2:45 a.m.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-34-2667

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 10, 1928

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5721 Grosvenor Lane

10f. Zip Code

20814

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Stock Broker

16b. Kind of Business/Industry

Finance & Investment

17. Father's Name (First, Middle, Last)

Rollin Meredith Bell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Alice McDonough

19a. Informant's Name/Relationship (Type, Print)

Rollin M. Bell, III / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3828 Village Park Drive, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

July 11, 2000

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

*J.C. Bell*

M00896

22. Name and Address of Facility

Robert A. Humphrey Funeral Home  
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

*pulmonary edema*

b.

Due to (or as a consequence of):

*congestive heart failure*

c.

Due to (or as a consequence of):

*ischemic cardiomyopathy*

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*demential, renal insufficiency*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*E. Goldstein MD*

29c. License number

DO 3587

29d. Date signed (Month, Day, Year)

July 7 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

E. Goldstein 9410 Old Georgetown Rd Bethesda, 20814

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

*Anna B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

ROLL IN BELL 245  
July 7, 2000

10 + 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23414

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          |                                                                                                                                                                                                     |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------|--|---------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>JULIE BENBASSETT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          | 2. Date of Death<br>Month Day Year<br>JULY 11, 2000                                                                                                                                                 |                                                                                      |                                                       |                                                                  | 3. Time of Death<br>11:01 PM                                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>HEBREW HOME OF GREATER WASHINGTON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          | 4b. City, Town, or Location of Death<br>ROCKVILLE                                                                                                                                                   |                                                                                      |                                                       |                                                                  | 4c. County of Death<br>MONTGOMERY                                                                                                                                                                        |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>092-03-8432                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                          | 7. Age (In yrs. last birthday)<br>85 Yrs.                                                                                                                                                           |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>AUGUST 8, 1914 |                                                                  | 9. Birthplace (State or Foreign Country)<br>NEW YORK                                                                                                                                                     |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          |                                                                                                                                                                                                     |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         | 10b. County<br>MONTGOMERY                                                                                                                             |                          | 10c. City, Town or Location<br>ROCKVILLE                                                                                                                                                            |                                                                                      |                                                       |                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>6121 MONTROSE ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          | 10f. Zip Code<br>20852                                                                                                                                                                              |                                                                                      | 10g. Citizen of What Country?<br>U.S.A.               |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                       | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CLERICAL OFFICE WORKER                                                                 |                                                                                      |                                                       |                                                                  | 16b. Kind of Business/Industry<br>DEBOLD SECURITY SYSTEMS                                                                                                                                                |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>SAMPSON ASSAEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          | 18. Mother's Name (First, Middle, Maiden Surname)<br>LAURA LEVY                                                                                                                                     |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19e. Informant's Name/Relationship (Type, Print)<br>MARVIN BENBASSETT SON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14020 RIPPLING BROOKE DR. SILVER SPRING MD. 20906                                                  |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>JUDEAN MEMORIAL GARDENS                                                     |                          | Date<br>JULY 14 2000                                                                                                                                                                                |                                                                                      | 20c. Location - City or Town, State<br>OLNEY, MD.     |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Donald C. Stottmeyer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC.<br>170 ROCKVILLE PIKE ROCKVILLE, MD. 20852                                                                             |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CEREBRAL THROMBOSIS 4 DAYS<br>Due to (or as a consequence of):<br>b. CEREBRAL ATHEROSCLEROSIS YEARS<br>Due to (or as a consequence of):<br>c. INSULIN DEPENDENT DIABETES MELLITUS YEARS<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          |                                                                                                                                                                                                     |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           | Approximate Interval Between Onset and Death |                                                                                                                                             |  |                                |  |                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ATRIAL FIBRILLATION<br>PERIPHERAL VASCULAR DISEASE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          |                                                                                                                                                                                                     |                                                                                      |                                                       |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                          |                                                                                                                                                                                                     |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |                                |  |                                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28e. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                                       | 28b. Time of Injury<br>M |                                                                                                                                                                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                       | 28d. Describe how injury occurred                                |                                                                                                                                                                                                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                              |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          |                                                                                                                                                                                                     |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              | 29b. Signature and Title of certifier<br>Steven Lipson MD                                                                                   |  | 29c. License number<br>D 05885 |  | 29d. Date signed (Month, Day, Year)<br>07/12/2000 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>STEVEN LIPSON 6121 MONTROSE ROAD ROCKVILLE                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                          |                                                                                                                                                                                                     |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 13 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                                                                                                                  |                                                                                                                                                       |                          |                                                                                                                                                                                                     |                                                                                      |                                                       |                                                                  |                                                                                                                                                                                                          |                                                                                                           |                                              |                                                                                                                                             |  |                                |  |                                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 23415

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>THEODORE C. BRIENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <b>July</b> Day <b>09</b> Year <b>2000</b>                                                                                                                         |  | 3. Time of Death<br><b>0930 AM</b>                                                                                                                                                               |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>4610 Overbrook Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                                                                                                                                      |  | 4c. County of Death<br><b>Montgomery</b>                                                                                                                                                         |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>226-20-7336</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 19, 1923</b>                                                                                                                                       |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                     |  | 10b. County<br><b>Montgomery</b>                                                                                                                                                             |  | 10c. City, Town or Location<br><b>Bethesda</b>                                                                                                                                                   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 10e. Street and Number<br><b>4610 Overbrook Road</b>                                                                                                                                         |  |                                                                                                                                                                                                  |  |
|                                               | 10f. Zip Code<br><b>20816</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-46</b>                                                                                                                            |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Planning Officer</b>                                                                                                                                                         |  | 16b. Kind of Business/Industry<br><b>F.A.A.</b>                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Elmer H. Brient</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pearl Elizabeth Reinbold</b>                                                                                                         |  |                                                                                                                                                                                                  |  |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kurt Brient (Son)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4738 Mt. Zion Road Frederick, MD 21703</b>                                               |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>                                                                                                                                                                                     |  | 20c. Date<br><b>07-12</b>                                                                                                                                                                    |  | 20d. Location - City or Town, State<br><b>Rockville, MD</b>                                                                                                                                      |  |
|                                               | 21. Signature of Funeral Service Licensee<br><b>Thomas E. Honnaker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22. Name and Address of Facility<br><b>JOSEPH GAWLER'S SONS, INC.<br/>5130 Wisconsin Ave., NW Washington, DC 20016</b>                                                                                                                                                                      |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>a. Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  | Approximate Interval Between Onset and Death<br><b>18 Months</b>                                                                                                                                 |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |  |
|                                               | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                          |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |  |
|                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|                                               | 29b. Signature and title of certifier<br><b>Kenneth Goldstein</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>D17211</b>                                                                                                                                                         |  | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                                                                                                                                      |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Kenneth Goldstein, MD 5480 Wisconsin Ave. #214 Chevy Chase, MD 20815</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|                                               | 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                |  |                                                                                                                                                                                                  |  |

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State of Maryland / Department of Health and Mental Hygiene

00 23416

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>KATHERINE BUAS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 2. Date of Death<br>Month Day Year<br><b>July 3, 2000</b>                                                                                                                                                                                                                                               |  | 3. Time of Death<br><b>9:01 PM</b>                                                                                                                    |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                                                                                                                                                                                                                                                 |  | 4c. County of Death<br><b>Montgomery</b>                                                                                                              |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-50-2498</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.                                                                                                                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 18, 1928</b>                                                                                           |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10a. State<br><b>MD</b>                                                        |  | 10b. County<br><b>Montgomery</b>                                                                                                                                                                                                                                                                        |  | 10c. City, Town or Location<br><b>Silver Spring</b>                                                                                                   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 10e. Street and Number<br><b>9713 Forest Grove Drive</b>                                                                                                                                                                                                                                                |  | 10f. Zip Code<br><b>20910</b>                                                                                                                         |  |
|                                               | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                 |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                          |  |
|                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                                                                                                                                                                                                                                                       |  | 17. Father's Name (First, Middle, Last)<br><b>Evangelos J. Moutsos</b>                                                                                |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Urania Zuppas</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Buas (Son)</b>                                                                                                                                                                                                                           |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11303 Palisades Court Kensington, MD 20895</b>    |  |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>                                                                                                                                                                                                |  | 20c. Location - City or Town, State<br><b>07/07 Silver Spring, MD</b>                                                                                 |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Thomas E. Hornbaker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 22. Name and Address of Facility<br><b>JOSEPH GAWLER'S SONS, INC.<br/>5130 Wisconsin Ave., NW Washington, DC 20016</b>                                                                                                                                                                                  |  |                                                                                                                                                       |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>metastatic breast cancer</b><br>Due to (or as a consequence of):<br><br>b. <b>breast cancer</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                |  | Approximate Interval Between Onset and Death<br><br><b>3 years</b><br><b>6 years</b>                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                |  |                                                                                                                                                       |  |
|                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |  |                                                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                       |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 28a. Date of Injury (Month, Day, Year)<br><br>28b. Time of Injury<br><b>M</b><br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br><br>28e. Location (Street and Number or Rural Route Number, City or Town, State)          |  |                                                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                |  |                                                                                |  | 29b. Signature and title of certifier<br><b>Peter Bishkas MD</b>                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  |
|                                               | 29c. License number<br><b>021531</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 29d. Date signed (Month, Day, Year)<br><b>July 4, 2000</b>                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PETER BISHKAS, MD., 11510 OLD GEORGETOWN RD. ROCKVILLE, MD. 20852</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                       |  |
|                                               | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |  |

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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>DAVID A. BUNN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                | 2. Date of Death<br>Month: <b>JULY</b> Day: <b>6</b> Year: <b>2000</b>                                                                                                                       |                                                                                             | 3. Time of Death<br><b>0955</b>                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>                                                                                                                                      |                                                                                             | 4c. County of Death<br><b>MONTGOMERY</b>                                                              |                                                                                                                                                                                                             |                                                                                                                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>452-20-5989</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                                                                                                              | If Under 1 Year<br>Months: Days:               | If Under 24 Hrs.<br>Hours: Min.                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>APR. 5, 1925</b>                                  |                                                                                                       | 9. Birthplace (State or Foreign Country)<br><b>TEXAS</b>                                                                                                                                                    |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10b. County<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                            |                                                                                                                                                               | 10c. City, Town or Location<br><b>BETHESDA</b> |                                                                                                                                                                                              |                                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |                                                                                                                                                                                                             |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>10305 DICKENS AVE.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               | 10f. Zip Code<br><b>20814</b>                  |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                               |                                                                                                                                                                                                             |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>5+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EXECUTIVE</b>                                 |                                                |                                                                                                                                                                                              | 16b. Kind of Business/Industry<br><b>TRADE ASSOCIATION</b>                                  |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>LLOYD THOMAS BUNN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROBINA ARMSTRONG</b>                                                                                                                 |                                                                                             |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARILYN L. BUNN/WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ITEM #10</b>                                                                     |                                                                                             |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>                                                           |                                                | Date<br><b>7/8/00</b>                                                                                                                                                                        |                                                                                             | 20c. Location - City or Town, State<br><b>RIVERDALE, MD.</b>                                          |                                                                                                                                                                                                             |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                | 22. Name and Address of Facility<br><b>MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>                                                                                         |                                                                                             |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                       | Approximate Interval Between Onset and Death                                                                                                                                                                |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                       | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                |                                                                                                                                                                                              |                                                                                             | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                               |                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                               | 28b. Time of Injury<br><b>M</b>                |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                       | 28d. Describe how injury occurred                                                                                                                                                                           |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                               |                                                |                                                                                                                                                                                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
| 29b. Signature and title of certifier<br> (M.D.)                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               | 29c. License number<br><b>015236</b>           |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>JULY 6, 2000</b>                                  |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. I. MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                           | 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             | 32. Registrar's Signature<br>                                             |                                                |                                                                                                                                                                                              |                                                                                             |                                                                                                       |                                                                                                                                                                                                             |                                                                                                                                                    |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 234181

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Geraldine V. Burk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br>July 10, 2000                                  |                                                           | 3. Time of Death<br>7:45 AM                                                                                                                                                                              |                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Carriage Hill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br>Bethesda                                     |                                                           | 4c. County of Death<br>Montgomery                                                                                                                                                                        |                                                            |                                                       |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>577-24-2968                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                           |                               | 7. Age (In yrs. last birthday)<br>83 Yrs.                                                                                                                                                        |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Oct. 10, 1916      |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Washington, DC |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 10b. County<br>Montgomery                                                                                                                                |                               | 10c. City, Town or Location<br>Bethesda                                                                                                                                                          |                                                                                      |                                                           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>5215 Cedar Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               | 10f. Zip Code<br>20814                                                                                                                                                                           |                                                                                      | 10g. Citizen of What Country?<br>United States            |                                                                                                                                                                                                          |                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                           |                                                                                      |                                                           | 16b. Kind of Business/Industry<br>Own Home                                                                                                                                                               |                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Ewell Kirk Jett                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lynne Ward                      |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br>Karen L. Sheffield/Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3203 Ravenscraig Court, Herndon, Virginia 20171                                                 |                                                                                      |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc.                                                   |                               | Date<br>July 12, 2000                                                                                                                                                                            |                                                                                      | 20c. Location - City or Town, State<br>Bethesda, Maryland |                                                                                                                                                                                                          |                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br> M00198                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.<br>7557 Wisconsin Avenue<br>Bethesda, Maryland 20814-3501 |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebral Vascular Accident<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                                                                                                                                                          |                                                            | Approximate Interval Between Onset and Death<br>hours |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>End Stage Oxygen Dependent Chronic Obstructive Pulmonary Disease<br>Osteoporosis, Osteoarthritis                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               |                                                                                                                                                                                                  |                                                                                      |                                                           | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                            |                                                       |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                          |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                          | 28b. Time of Injury<br>M      |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                           | 28d. Describe how injury occurred                                                                                                                                                                        |                                                            |                                                       |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 29b. Signature and title of certifier<br>                                                                                                                                                                            |                                                                                                                                                          | 29c. License number<br>D35579 |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br>July 11, 2000                                 |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Susan J. Miller, M.D. 6844 Tulip Hill Terrace, Bethesda, Maryland 20816                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |
| 31. Date filed (Month, Day, Year)<br>JUL 12 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 32. Registrar's Signature<br>                                                                                                                                                                                       |                                                                                                                                                          |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                                                                                                                                                          |                                                            |                                                       |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23419

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Dorothy Helen Brooks                               |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month: July Day: 11 Year: 2000                                                                                                                                                |                                                                                                                                                |                                              |                                                                                                    | 3. Time of Death<br>2150                                         |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>Kent & Queen Anne's Hospital |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Chestertown                                                                                                                                               |                                                                                                                                                |                                              |                                                                                                    | 4c. County of Death<br>Kent                                      |                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>218-36-0847                                                       |                     | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>94 Yrs.                                                                                                                                                         |                                                                                                                                                | If Under 1 Year<br>Months: Days: Hours: Min. |                                                                                                    | 8. Date of Birth (Month, Day, Year)<br>February 2, 1906          |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland                                           |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                | 10b. County<br>Kent |                                                                                                                                                       | 10c. City, Town or Location<br>Galena                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                                                                |                                              | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                  |                                   |  |
| 10e. Street and Number<br>13893 Gregg Neck Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |                     |                                                                                                                                                       | 10f. Zip Code<br>21635                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                   |                                                                                                                                                |                                              | 10g. Citizen of What Country?<br>United States                                                     |                                                                  |                                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                |                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                |                                              |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                     |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                  |                                                                                                                                                                                                   |                                                                                                                                                |                                              | 16b. Kind of Business/Industry<br>Domestic - Own Home                                              |                                                                  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br>John Filliaux                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sophia Deems                                                                              |                                              |                                                                                                    |                                                                  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Reverend Earl Brooks - Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13893 Gregg Neck Road, Galena, Maryland 21635 |                                              |                                                                                                    |                                                                  |                                   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |                     |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery                                                                                                                                                                                                          |                                                                                                                                                                                                   | Date<br>July 14, 2000                                                                                                                          |                                              | 20c. Location - City or Town, State<br>Baltimore, Maryland                                         |                                                                  |                                   |  |
| 21. Signature of Funeral Service Licensee<br>William L. King, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                     |                                                                                                                                                       | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>370 Cypress Street, PO Box 270, Millington, Md                                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Pancreatitis</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Alzheimer's / Osteoporosis</u>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                |                     |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                          |                                                                                                |                     |                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                   | 28b. Time of Injury<br>M                                                                                                                       |                                              | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                                  | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                |                     |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                   |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 29b. Signature and title of certifier<br>Neil Stoddard MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                |                     |                                                                                                                                                       | 29c. License number<br>D50996                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                   |                                                                                                                                                |                                              | 29d. Date signed (Month, Day, Year)<br>7/12/00                                                     |                                                                  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Neil Stoddard MD 100 Brown St Chestertown MD 21620                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                |                     |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                |                     |                                                                                                                                                       | 32. Registrar's Signature<br>P. Sparks                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                   |                                                                                                                                                |                                              |                                                                                                    |                                                                  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2024.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23420

Amended #26,07/12/00,t.m., Kent Co.

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  |                                                                      |                                                                                                                                                                                                          |                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><u>Wayne D. Bishop</u>                       |                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  | 2. Date of Death<br>Month <u>June</u> Day <u>29</u> Year <u>2000</u> |                                                                                                                                                                                                          | 3. Time of Death<br><u>10:40p.m.</u>                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><u>13 Walden Court</u> |                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><u>North East</u>            |                                                                                                                                                                                                          | 4c. County of Death<br><u>Cecil County</u>              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><u>222-42-3286</u>                                          |                                                                                                                                                                                                                                                                                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><u>40</u> Yrs.                     |                                                                                                                                                                                                          | 8. Date of Birth (Month, Day, Year)<br><u>9/24/1959</u> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                              |                                                                                                                                                                                                                                                                                                                 | 10a. State<br><u>Maryland</u>                                              |                                                                                                                                                                                                  | 10b. County<br><u>Cecil</u>                                          |                                                                                                                                                                                                          | 10c. City, Town or Location<br><u>North East</u>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          | 10e. Street and Number<br><u>13 Walden Court</u>                                                                                                                                                                                                                                                                |                                                                            | 10f. Zip Code<br><u>21901</u>                                                                                                                                                                    |                                                                      | 10g. Citizen of What Country?<br><u>USA</u>                                                                                                                                                              |                                                         |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                                                                                                                                  |                                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Painter</u>                                                                                                                                                                                     |                                                                            | 16b. Kind of Business/Industry<br><u>Painting</u>                                                                                                                                                |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| 17. Father's Name (First, Middle, Last)<br><u>Paul Bishop</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            | 18. Mother's Name (First, Middle, Maiden Summa)<br><u>Kitty Bishop</u>                                                                                                                           |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Mary-Kathryn Marcum</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>13 Walden Court, North East, Maryland 21901</u>                                              |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Chesapeake Cremation center, LLC 7/1/2000</u>                                                                                                                                                                                      |                                                                            | 20c. Location - City or Town, State<br><u>Stevensville, Maryland</u>                                                                                                                             |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          | 22. Name and Address of Facility<br><u>Fellows, Helfenbein &amp; Newman Funeral Home, P.a.<br/>226 E. Main street, Cecilton, Maryland 21913</u>                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Advanced Cirrohosis of Liver 2" to ETOH</u><br>Due to (or as a consequence of):<br>b. <u>Hepatitis C</u><br>Due to (or as a consequence of):<br>c. <u></u><br>Due to (or as a consequence of):<br>d. <u></u><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            | Approximate Interval Between Onset and Death<br><u>11 days</u>                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  |                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  |                                                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                         |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                                  |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          | 28a. Date of Injury (Month, Day, Year)<br><u></u>                                                                                                                                                                                                                                                               |                                                                            | 28b. Time of Injury<br><u>M</u>                                                                                                                                                                  |                                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          | 28d. Describe how injury occurred<br><u></u>                                                                                                                                                                                                                                                                    |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><u></u>                                                                                                |                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u></u>                                                                                                                  |                                                         |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            | 29c. License number<br><u>D07463</u>                                                                                                                                                             |                                                                      | 29d. Date signed (Month, Day, Year)<br><u>6/30/2000</u>                                                                                                                                                  |                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Dr. John Mulvey, 111 West High Street, Elkton, Maryland 21921</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  |                                                                      |                                                                                                                                                                                                          |                                                         |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 12 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                  |                                                                      |                                                                                                                                                                                                          |                                                         |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry G. Bennett

2. Date of Death  
Month Day Year

July 7, 2000

3. Time of Death

5:15 AM

4a. Facility Name (If not institution, give street and number)

6509 Marvin Avenue

4b. City, Town, or Location of Death

Eldersburg

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

216-28-9962

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 1, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6509 Marvin Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Serviceman

16b. Kind of Business/Industry

Tire Repair

17. Father's Name (First, Middle, Last)

George A. Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Hattie M. Leatherwood

19a. Informant's Name/Relationship (Type, Print)

Mrs. Alice Bennett (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6509 Marvin Avenue Eldersburg, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lake View Mem. Park

Date

7/12/2000 Eldersburg, MD

21. Signature of Funeral Service Licensee

Bryan L. Hayles

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)  
Sykesville, MD 21784 (410)-795-140023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Lung cancer

Due to (or as a consequence of):

f.

Due to (or as a consequence of):

g.

Due to (or as a consequence of):

h.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

1 1/2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None Known

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard Sautz M.D.

29c. License number

D15552

29d. Date signed (Month, Day, Year)

7/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Sautz, M.D. 224 Washington Heights Westminster, Md. 21157

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
50232.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

23422

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN ROBERT BEDSWORTH

2. Date of Death

Month Day Year  
JULY 5, 2000

3. Time of Death

1540

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral  
Director

5. Social Security Number

215-26-7379

6. Sex

2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10-27-31

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

WORCESTER

10c. City, Town or Location

OCEAN CITY

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12637 SHEFFIELD RD.

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALESMAN

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

NORWOOD BEDSWORTH

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED CROPPER

19a. Informant's Name/Relationship (Type, Print)

LEIGHTON W. MOORE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BROTHER 12637 SHEFFIELD RD. OCEAN CITY, ME, 21842

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SALISBURY CREMATORY

Date

7-6

20c. Location - City or Town, State

SALISBURY, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic lung cancer

Approximate Interval Between Onset and Death

months

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D047676

29d. Date signed (Month, Day, Year)

7/5/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BROTHER TIGULIMAT 8733 HOSPITALWAY DR BERLIN MD 21811

State  
Registrar

31. Date filed (Month, Day, Year)

III 11 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Bedsworth, John Robert, 10/27/31, 68yo WM, 215-26-7379, 7/5/00 1540, Baltimore, Maryland 21215-0020. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23423

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    |                                                                                                                                                                                              |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>John Robert Brennan, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    | 2. Date of Death<br>Month Day Year<br><b>July 2, 2000</b>                                                                                                                                    |                                                                                             | 3. Time of Death<br><b>2:29 pm</b>                                                             |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Future Care Chesapeake</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    | 4b. City, Town, or Location of Death<br><b>Arnold</b>                                                                                                                                        |                                                                                             | 4c. County of Death<br><b>Anne Arundel</b>                                                     |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>383-01-4736</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                                                                                                              | If Under 1 Year<br>Months Days                     | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>June 3, 1919</b>                                  |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Michigan</b>                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    |                                                                                                                                                                                              |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                          |                                                                                                                                                               | 10c. City, Town or Location<br><b>Severna Park</b> |                                                                                                                                                                                              |                                                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>123 Arundel Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               | 10f. Zip Code<br><b>21146</b>                      |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>5+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive, Ford Motor Co.</b>                 |                                                    |                                                                                                                                                                                              | 16b. Kind of Business/Industry<br><b>Automobile</b>                                         |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>John Peter Brennan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna McCarthy</b>                                                                                                                    |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marjorie Brennan/ wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>123 Arundel Avenue, Severna Park, MD 21146</b>                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery</b>                                                         |                                                    | Date<br><b>July 18 2000</b>                                                                                                                                                                  |                                                                                             | 20c. Location - City or Town, State<br><b>Crownsville, MD</b>                                  |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>                                             |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>mitral valve endocarditis</b><br>Due to (or as a consequence of):<br>c. <b>with subvalvular abscess</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><br><b>days</b><br><b>weeks</b> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    |                                                                                                                                                                                              |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>porcine aortic valve, cardiac pacemaker, coronary bypass, advanced Alzheimers Disease</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    |                                                                                                                                                                                              |                                                                                             |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                               |                                                    |                                                                                                                                                                                              |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                               | 28b. Time of Injury<br><b>M</b>                    |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                                                                                                                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                                                                                                               | 29c. License number<br><b>D41955</b>               |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>7-3-00</b>                                        |                                                                                                |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rebecca L. M. 479 Jumpers Hole Rd #304 Severna Park MD 21146</b>                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                    |                                                                                                                                                                                              |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                                                                                                                               |                                                    |                                                                                                                                                                                              |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



7/11/00 10:00 AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23424

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |  |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                                                                                |                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH R. BURTON</b>                       |  |                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>July</b> Day <b>14</b> Year <b>2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>12<sup>30</sup> P.M.</b>                                                |                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not Institution, give street and number)<br><b>6276 Loveknot Place</b> |  |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Columbia</b>              |                                                                                                                                                                                              | 4c. County of Death<br><b>Howard</b>                                                           |                                                                                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br><b>223-05-3640</b>                                              |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                     |                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>Feb 13, 1912</b>                                     |                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10a. State<br><b>MD</b>                                                                      |  | 10b. County<br><b>Howard</b>                                               |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Columbia</b>                       |                                                                                                                                                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |  |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |  |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Government Custodial</b>                                                                                                                                                    |                                                                      | 16b. Kind of Business/Industry<br><b>Domestic</b>                                                                                                                                            |                                                                                                |                                                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Claude Rogers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |  |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ada Ross</b>                                                                                                                                                                                                                        |                                                                      |                                                                                                                                                                                              |                                                                                                |                                                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Alice Ada Jefferson/Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |  |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6276 Loveknot Place Columbia, Maryland 21045</b>                                                                                                                                        |                                                                      |                                                                                                                                                                                              |                                                                                                |                                                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |  |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenwood Memorial Gard. 7-18-2000 Goochland Co., VA.</b>                                                                                                                                                      |                                                                      | 20c. Location - City or Town, State                                                                                                                                                          |                                                                                                |                                                                                             |  |
| 21. Signature of Funeral Service Licensee<br><b>Sharon A. Collins-Witzke</b> <b>MO1044</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |  |                                                                            | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family Funeral Home, Inc.</b><br><b>4112 Old Columbia Pike Ellicott City, MD 21043</b>                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                                                                                |                                                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pancreatic Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                              |  |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                      | Approximate Interval Between Onset and Death<br><b>2 months</b>                                                                                                                              |                                                                                                |                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Breast Cancer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |  |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                                      |                                                                                                                                                                                              |                                                                                                |                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |  |                                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                           |                                                                                                |                                                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |  |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                      |                                                                                                                                                                                              |                                                                                                |                                                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |  |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                      | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |  |                                                                            | 28d. Describe how Injury occurred                                                                                                                                                                                                                                                           |                                                                      | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                                                |                                                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                    |                                                                                              |  |                                                                            | 29b. Signature and title of certifier<br><b>[Signature] M.D.</b>                                                                                                                                                                                                                            |                                                                      | 29c. License number<br><b>241139</b>                                                                                                                                                         |                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>July 14, 2000</b>                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Clement Knight MD 11065 Little Patuxent Pkwy Columbia MD 21044</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |  |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                                                                                |                                                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |  |                                                                            | 32. Registrar's Signature<br><b>[Signature] B. Sparks</b>                                                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                              |                                                                                                |                                                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

For we

Can we

PELLE  
1 hour

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23425

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>KARL BEAZLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <b>July</b> Day <b>12</b> Year <b>2000</b>                                                                                                                          |  | 3. Time of Death<br><b>9:53 PM</b>                                                                                                                                                                          |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>                                                                                                                                   |  | 4c. County of Death<br><b>BALTIMORE</b>                                                                                                                                                                     |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-38-7893</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.                                                                                                                                              |  | 8. Date of Birth (Month, Day, Year)<br><b>April 25, 1942</b>                                                                                                                                                |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                               |  | 10b. County<br><b>Carroll</b>                                                                                                                                                                 |  | 10c. City, Town or Location<br><b>Sykesville</b>                                                                                                                                                            |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10e. Street and Number<br><b>6301 Barnett Ave.</b>                                                                                                                                                                                                                                          |  | 10f. Zip Code<br><b>21784</b>                                                                                                                                                                 |  | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                                       |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Contractor</b>                                                                                                                                                              |  | 16b. Kind of Business/Industry<br><b>Self-employed</b>                                                                                                                                        |  |                                                                                                                                                                                                             |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>Robert H. Beazley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kathryn E. Beazley</b>                                                                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dr. Robert Beazley / brother</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>45 W. Newton St. Boston, MA. 02118</b>                                                                                                                                                  |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
|                                               | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                                                                                                                                                            |  | Date<br><b>7-15-2000</b>                                                                                                                                                                      |  | 20c. Location - City or Town, State<br><b>Catonsville, MD.</b>                                                                                                                                              |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD. 21043</b>                                                                                                                                                  |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. <u>Acute Myocardial Infarction</u></b><br>Due to (or as a consequence of):<br><b>b. <u>Coronary Artery Disease</u></b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>1 hour</b><br><b>years</b>                                                                                                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                          |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                 |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
|                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
|                                               | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 29c. License number<br><b>D97587</b>                                                                                                                                                                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>July 12, 2000</b>                                                                                                                                   |  |                                                                                                                                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT FINE MD 5401 OLD LOUIS ROAD, RANDALLSTOWN MD 21133</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |
|                                               | 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. Registrar's Signature<br>                                                                                                                                                                            |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                             |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23426

|                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               |                                                                                  |                                                                                                                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>SARAH CATHERINE BIDDINGER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 8, 2000</b>                                                                                                                                     |                                                                                  | 3. Time of Death<br><b>4:11 PM</b>                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>Northampton Manor Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Frederick</b>                                                                                                                                      |                                                                                  | 4c. County of Death<br><b>Frederick</b>                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>220-40-0566</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.                                                                                                                                              |                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 16, 1909</b>                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>Maryland</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10b. County<br><b>Frederick</b>                                                                                                                                                               |                                                                                  | 10c. City, Town or Location<br><b>Frederick</b>                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                     | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             | 10e. Street and Number<br><b>200 East Sixteenth Street</b>                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10f. Zip Code<br><b>21701</b>                                                                                                                                                                 |                                                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                         | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                                                                                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |  |
|                                                                                                                                                                                                                                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (14 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |                                                                                                                                                                                                                                                                                                                                                                                                                              | 16b. Kind of Business/Industry<br><b>Own Home</b>                                                                                                                                             |                                                                                  |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                         | 17. Father's Name (First, Middle, Last)<br><b>Robert Simon Downs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Zella Mae Powell</b>                                                                                                                  |                                                                                  |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>G. Frances Hann (Daughter)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 Lombard Street, Thurmont, Maryland 21788</b>                                            |                                                                                  |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                         | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Paul's Cemetery</b>                                              |                                                                                                                                                                                                                                                                                                                                                                                                                              | 20c. Location - City or Town, State<br><b>Utica, Maryland</b>                                                                                                                                 |                                                                                  | 20d. Date<br><b>7/11/00</b>                                                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                         | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              | 22. Name and Address of Facility<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>615 EAST MAIN ST., THURMONT, MD 21788</b>                                                           |                                                                                  |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. DEMENTIA (ALZHEIMER'S; END-STAGE)</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               |                                                                                  |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RIGHT HIP FRACTURE</b><br><b>ATRIAL FIBRILLATION / SICK SINUS SYNDROME</b><br><b>CONGESTIVE HEART FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               |                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               |                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               |                                                                                  |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                               |                                                                                  |                                                                                                                                                                                                  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                               |                                                                                  |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 29c. License number<br><b>D32171</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>7/10/00</b>                            |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Richard L. Gough, MD 19 Frederick Street, Walkersville, MD 21793</b>                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               |                                                                                  |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               |                                                                                  |                                                                                                                                                                                                  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23427

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         |                                                          |                                                                              |                                                            |                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS BRADFORD</b>                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>JULY 8 2000</b> |                                                                              | 3. Time of Death<br><b>~ 2 AM</b>                          |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>10212 Hickory Ridge Road - Apt. 304</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |                                                                              | 4c. County of Death<br><b>Howard</b>                       |                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>578-52-8374</b>                                                              |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.         |                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>May 15, 1940</b> |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>                                          |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                                                                                         | 10b. County<br><b>Howard</b>                             |                                                                              | 10c. City, Town or Location<br><b>Columbia</b>             |                                                |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                              |                                                                            | 10e. Street and Number<br><b>10212 Hickory Ridge Road - Apt. 304</b>                                                                                                                                                                                                    |                                                          | 10f. Zip Code<br><b>21044</b>                                                |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b> |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                     |                                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                           |                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>      |                                                            |                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                              | College (14 or 5+) <b></b>                                                                                                                                                                                                                                                                  |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                                                                                                                                        |                                                          | 16b. Kind of Business/Industry<br><b>Delivery</b>                            |                                                            |                                                |  |
| 17. Father's Name (First, Middle, Last)<br><b>Francis Eugene Bradford</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Alice Delores Nalley</b>                                                                                                                                                                                          |                                                          |                                                                              |                                                            |                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Paula Marie Bradford - Wife</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10212 Hickory Ridge Road-#304, Columbia, Maryland 21044</b>                                                                                                         |                                                          |                                                                              |                                                            |                                                |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                              |                                                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematorium</b>                                                                                                                                                                                   |                                                                            | Date<br><b>7/13/00</b>                                                                                                                                                                                                                                                  |                                                          | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>           |                                                            |                                                |  |
| 21. Signature of Funeral Service Licensee<br><b>Robert L. Williams</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>Olin L. Molesworth P.A., Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872-0117</b>                                                                                                                                    |                                                          |                                                                              |                                                            |                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                              | a. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):                                                                                                                                                                                                        |                                                                            | b. <b>Hypercholesterolemia</b><br>Due to (or as a consequence of):                                                                                                                                                                                                      |                                                          | c.<br>Due to (or as a consequence of):                                       |                                                            | d.<br>Due to (or as a consequence of):         |  |
| Approximate Interval Between Onset and Death<br><b>years</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                              | <b>month</b>                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                         |                                                          |                                                                              |                                                            |                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>borderline hypertension</b>                                                                                                                                                                                                                                                                                           |                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                        |                                                          |                                                                              |                                                            |                                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                              |                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                      |                                                          |                                                                              |                                                            |                                                |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |                                                          | 28a. Date of Injury (Month, Day, Year)<br><b>2000</b>                        |                                                            | 28b. Time of Injury<br><b>M</b>                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                        |                                                                                                              | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                  |                                                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                            |                                                |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |                                                                                                              | 29b. Signature and title of certifier<br><b>Deputy ME<br/>Howard</b>                                                                                                                                                                                                                        |                                                                            | 29c. License number<br><b>D31473</b>                                                                                                                                                                                                                                    |                                                          | 29d. Date signed (Month, Day, Year)<br><b>July 9, 2000</b>                   |                                                            |                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PATRYCE A -TOTE, MD 4565 Hemlock Cone Way Ellicott City MD 21042</b>                                                                                                                                                                                                                                                                                    |                                                                                                              | 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                     |                                                                            | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                         |                                                          |                                                                              |                                                            |                                                |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23428

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------|---------------------|---------------------------------------------------------------|-------------------------|----------------|----|--|----|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>JANE M. BERNSDORFF</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 2. Date of Death<br>Month Day Year<br><b>JULY 9 2000</b>                                                                                                                                         |                                                                                                                                                                                                          | 3. Time of Death<br><b>5:45 am</b>                                      |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4e. Facility Name (If not institution, give street and number)<br><b>19010 WHITES FERRY ROAD</b>                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 4b. City, Town, or Location of Death<br><b>POOLESVILLE</b>                                                                                                                                       |                                                                                                                                                                                                          | 4c. County of Death<br><b>MONTGOMERY</b>                                |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>214-52-3927</b>                                                                                                                                                                                                                                                                                                                        | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                                                                                                      | If Under 1 Year<br>Months Days                                               | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   | 8. Date of Birth (Month, Day, Year)<br><b>JAN 14 1915</b>                                                                                                                                                |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>NC</b> |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                | 10b. County<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                                        | 10c. City, Town or Location<br><b>POOLESVILLE</b>                                                                                                     |                                                                              |                                                                                                                                                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br><b>19010 WHITES FERRY RD.</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 10f. Zip Code<br><b>20837</b>                                                |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                           |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>                         |                                                                              |                                                                                                                                                                                                  | 16b. Kind of Business/Industry<br><b>DOMESTIC</b>                                                                                                                                                        |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br><b>HARVEY HOOPER MACKAY</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARTHA NASH WRIGHT</b>                                                                                                                   |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLES STOWERS/SON</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19010 WHITES FERRY RD., POOLESVILLE, MD 20837</b>                                            |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                        |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON NAT. CEMETERY 7/19 ARLINGTON, VA</b>                           |                                                                              | 20c. Location - City or Town, State                                                                                                                                                              |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 22. Name and Address of Facility<br><b>Hilton Funeral Home<br/>Box 86, Barnesville, MD 20838</b>                                                                                                 |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. <b>Pneumonia</b></td> <td>Approximate Interval Between Onset and Death<br/><b>7 days</b></td> </tr> <tr> <td>b. <b>Renal Failure</b></td> <td><b>4 years</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       | Immediate Cause (Final disease or condition resulting in death) | e. <b>Pneumonia</b> | Approximate Interval Between Onset and Death<br><b>7 days</b> | b. <b>Renal Failure</b> | <b>4 years</b> | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                               | e. <b>Pneumonia</b>                                                                                                                                                                                                                                                                                                                                                    | Approximate Interval Between Onset and Death<br><b>7 days</b>                                                                                                                                                                                                                                           |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | b. <b>Renal Failure</b>                                                                                                                                                                                                                                                                                                                                                | <b>4 years</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | c.                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | d.                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                   |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                              |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                                         | 28d. Describe how injury occurred                     |                                                                 |                     |                                                               |                         |                |    |  |    |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 29c. License number<br><b>(D.C.) MD 21675</b>                                |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br><b>JULY 10, 2000</b>                                                                                                                                              |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James D. Oliver III Walter Reed Army Med Ctr Washington, DC 20307</b>                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                        | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                         |                                                       |                                                                 |                     |                                                               |                         |                |    |  |    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,c per phys. G785 7/25/00 yg

## Certificate of Death

Reg. No.

00 23429

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ARTHUR BIGELSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 2. Date of Death<br>Month <u>July</u> Day <u>14<sup>th</sup></u> Year <u>2000</u>                                                                                                                                                                                                           |                                                                         | 3. Time of Death<br><u>4<sup>10</sup> pm</u>                                                   |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>HEBREW HOME OF GREATER WASHINGTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>                                                                                                                                                                                                                                    |                                                                         | 4c. County of Death<br><b>MONTGOMERY</b>                                                       |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>004-01-6147</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                    |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                                                                                                                                              |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 18, 1919</b>                                                                                                                                                                                                                                 |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>MAINE</b>                                       |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. County<br><b>MONTGOMERY</b>                                                                                                                              |  | 10c. City, Town or Location<br><b>BETHESDA</b>                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                               | 10e. Street and Number<br><b>5450 WHITLEY PARK TER. # 403</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                               |  | 10f. Zip Code<br><b>20814</b>                                                                                                                                                                 |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                                                                                                                                                                                                                                       |                                                                         |                                                                                                |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                                                                                                                                                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                                                                |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                               |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PARTNER / OWNER</b>                                                           |  |                                                                                                                                                                                                                                                                                             | 16b. Kind of Business/Industry<br><b>CONSULTING ENGINEER</b>            |                                                                                                |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH BIGELSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FANNIE GREENSTEIN</b>                                                                                                                                                                                                               |                                                                         |                                                                                                |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>RUTH T. BIGELSON / WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5450 WHITLEY PARK TER. # 403 BETHESDA, MD</b>                                                                                                                                           |                                                                         |                                                                                                |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. LEBANON CEM.</b>                                                             |  | 20c. Date<br><b>06/17/00</b>                                                                                                                                                                  |  | 20d. Location - City or Town, State<br><b>ADELPHI MD.</b>                                                                                                                                                                                                                                   |                                                                         |                                                                                                |  |
|                                               | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 22. Name and Address of Facility<br><b>BORGWARDT FUNERAL HOME 4400 POWDER MILL BELTSVILLE, MD 20705</b>                                                                                                                                                                                     |                                                                         |                                                                                                |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>acute cardio-pulmonary arrest</u><br>Due to (or as a consequence of):<br>b. <u>coronary artery disease</u><br>Due to (or as a consequence of):<br>c. <u>CEREBROVASCULAR ACCIDENT (acute)</u><br>Due to (or as a consequence of):<br>d. <u>aspiration / electrolyte imbalance</u><br>Due to (or as a consequence of):<br><u>cerebrovascular accident (acute)</u> |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
|                                               | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>congestive heart failure</u> <u>hypertension</u> <u>hypothyroidism</u> <u>Bipolar Disease</u> <u>gastrointestinal bleeding</u>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                                         |                                                                                                |  |
| State Registrar                               | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                         |                                                                                                |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                               |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                        |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |                                                                         | 28d. Describe how injury occurred                                                              |  |
|                                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                          |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 29b. Signature and title of certifier<br><i>[Signature]</i> <b>Consuelo Alvarez</b>                                                                                                                                                                                                         |                                                                         | 29c. License number<br><b>D:44907</b>                                                          |  |
|                                               | 29d. Date signed (Month, Day, Year)<br><b>July 14<sup>th</sup> 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Consuelo Alvarez, 6121 Montrose Road, Rockville, MD 20852</b>                                                                                                                                    |                                                                         |                                                                                                |  |
|                                               | 31. Date filed (Month, Day, Year)<br><b>JUL 24 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                               |  |                                                                                                                                                                                               |  | 32. Registrar's Signature<br><i>[Signature]</i> <b>Sparks</b>                                                                                                                                                                                                                               |                                                                         |                                                                                                |  |





1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ernestine J. Bailey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>7</b> - DAY <b>3</b> - YEAR <b>00</b>                                                                                                                                                                                                                                                                                                                                                           |  | 3. TIME OF DEATH<br><b>11:40 P.M.</b>                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-24-4943</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.                                                                                                                                                                                                                                                                                                                                                                             |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4.4.29</b>                                                                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3925 Market St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Snow Hill</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>                                                                                                      |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Worcester</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br><b>Snow Hill</b>                                                                                              |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>3925 Market St.</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21863</b>                                                                                                                |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Social Worker</b>                                                                                                                                                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Worcester County</b>                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James A. Jones Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Evelyn Truitt</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Betty Miles - Sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>32113 Perryhawk Rd., Princess Anne, MD 21853</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ebenezer Church Cem. 7.9.00</b>                                                                                                                                                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>Snow Hill, MD</b>                                                                                  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>A. E. Walz</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Anthony E. Ward Funeral Home<br/>30639 Hampden Ave, Princess Anne, MD</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC RENAL CELL CARCINOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death: <b>MONTHS</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                              |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mohan Bhat MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>00055006</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>07-05-2000</b>                                                                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mohan R. Bhat MD 6143 Eastern Shore Dr. Salisbury MD 21804</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 07 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>Geneva S. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23431

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>WALTER BURKE JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                        |                                                                                                                                                                  |                                 | 2. Date of Death<br>Month Day Year<br><b>JUNE 26 2000</b>                                                                                                                                    |                                                                                             |                                                                |                                                                         | 3. Time of Death<br><b>2:30 pm</b>                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>215 SCHOOL HOUSE LANE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        |                                                                                                                                                                  |                                 | 4b. City, Town, or Location of Death<br><b>GRASONVILLE</b>                                                                                                                                   |                                                                                             |                                                                |                                                                         | 4c. County of Death<br><b>QUEEN ANNE</b>                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>213-22-4814</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F                                                                                                                 |                                 | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                                                                                                                                             |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 29 1926</b>     |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                        |                                                                                                                                                                  |                                 |                                                                                                                                                                                              |                                                                                             |                                                                |                                                                         |                                                                      |                                                                                                                                                                                                                                                 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                 |  |                                                       |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                        | 10b. County<br><b>QUEEN ANNE</b>                                                                                                                                 |                                 | 10c. City, Town or Location<br><b>GRASONVILLE</b>                                                                                                                                            |                                                                                             |                                                                |                                                                         | 10d. Inside City Limits<br><b>XX</b> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>215 SCHOOL HOUSE LANE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                        |                                                                                                                                                                  |                                 | 10f. Zip Code<br><b>21638</b>                                                                                                                                                                |                                                                                             | 10g. Citizen of What Country?<br><b>USA</b>                    |                                                                         |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-46</b> |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             |                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>black</b> |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                        |                                                                                                                                                                  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MAINTENANCE</b>                                                              |                                                                                             |                                                                | 16b. Kind of Business/Industry<br><b>CHESAPEAKE BAY MODEL</b>           |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>WALTER BURKE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        |                                                                                                                                                                  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARTHA WATKINS</b>                                                                                                                   |                                                                                             |                                                                |                                                                         |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>GERALDINE BURKE (WIFE)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                        |                                                                                                                                                                  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21638 215 SCHOOL HOUSE LANE GRASONVILLE, MD.</b>                                            |                                                                                             |                                                                |                                                                         |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                             |                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ROBINSON CHURCH CEME.</b>                                                           |                                 | Date<br><b>7/1/00</b>                                                                                                                                                                        |                                                                                             | 20c. Location - City or Town, State<br><b>GRASONVILLE, MD.</b> |                                                                         |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br><b>Harry B. Reese M00482</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                        |                                                                                                                                                                  |                                 | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>                                                                             |                                                                                             |                                                                |                                                                         |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>Seizure</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                        |                                                                                                                                                                  |                                 |                                                                                                                                                                                              |                                                                                             |                                                                |                                                                         |                                                                      |                                                                                                                                                                                                                                                                                             | Approximate Interval Between Onset and Death<br><b>11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000</b> |                                               |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Seizures for many years</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                        |                                                                                                                                                                  |                                 |                                                                                                                                                                                              |                                                                                             |                                                                |                                                                         |                                                                      |                                                                                                                                                                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                               |  |                                                       |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        |                                                                                                                                                                  |                                 |                                                                                                                                                                                              |                                                                                             |                                                                |                                                                         |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        |                                                                                                                                                                  |                                 |                                                                                                                                                                                              |                                                                                             |                                                                |                                                                         |                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28a. Date of Injury (Month, Day, Year) |                                                                                                                                                                  | 28b. Time of Injury<br><b>M</b> |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                | 28d. Describe how injury occurred                                       |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        |                                                                                                                                                                  |                                 |                                                                                                                                                                                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                |                                                                         |                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               |  |                                                       |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        |                                                                                                                                                                  |                                 |                                                                                                                                                                                              |                                                                                             |                                                                |                                                                         |                                                                      | 29b. Signature and title of certifier<br><b>Ralph E. Libby M.D.</b>                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 29c. License number<br><b>D0005754</b>        |  | 29d. Date signed (Month, Day, Year)<br><b>6-28-00</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ralph E. Libby M.D. P.O. Box 458 204 Medical Rd. Grasonville Md. 21638</b>                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        |                                                                                                                                                                  |                                 |                                                                                                                                                                                              |                                                                                             |                                                                |                                                                         |                                                                      | 31. Date filed (Month, Day, Year)<br><b>JUL 03 2000</b>                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 32. Registrar's Signature<br><b>B. Sports</b> |  |                                                       |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23432

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Arthur William Bishop, Sr.                          |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>June 20, 2000 |                                                                                                                                                                                                   |                                |                                                                                                    | 3. Time of Death<br>5:05 p.m.                                    |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>Washington Adventist Hospital |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Takoma Park |                                                                                                                                                                                                   |                                |                                                                                                    | 4c. County of Death<br>Montgomery                                |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>219-48-7542                                                        |                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                            |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>52 Yrs.           |                                                                                                                                                                                                   | If Under 1 Year<br>Months Days |                                                                                                    | If Under 24 Hrs.<br>Hours Min.                                   |                                                           | 8. Date of Birth (Month, Day, Year)<br>Feb. 25, 1948 |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                                     |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 | 10b. County<br>Prince George's |                                                                                                                                                       | 10c. City, Town or Location<br>Hyattsville                                                                                                                                                                                                                                                              |                                                     |                                                                                                                                                                                                   |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 10e. Street and Number<br>6412 Baltimore Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                |                                                                                                                                                       | 10f. Zip Code<br>20782                                                                                                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                   |                                | 10g. Citizen of What Country?<br>United States                                                     |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         |                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Plumber                                                                                                                                                                                    |                                                     |                                                                                                                                                                                                   |                                | 16b. Kind of Business/Industry<br>Own Business                                                     |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 17. Father's Name (First, Middle, Last)<br>Trone Thompson Bishop, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br>Doris Elizabeth Kaldenbach                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 19e. Informant's Name/Relationship (Type, Print) (Brother)<br>Trone Thompson Bishop, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3770 Angleton Ct., Burtonsville, Maryland 20866                                                  |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery                                                                                                                                                                                                           |                                                     |                                                                                                                                                                                                   |                                | Date<br>June 26 2000                                                                               |                                                                  | 20c. Location - City or Town, State<br>Suitland, Maryland |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 21. Signature of Funeral Service Licensee<br><i>Laura C. Hardesty</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     | 22. Name and Address of Facility<br>Rapp Funeral and Cremation Services<br>933 Gist Ave., Silver Spring, Md. 20910                                                                                |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Alcoholic Cirrhosis of Liver</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      | Approximate Interval Between Onset and Death<br>years                                                                                                                                                    |                                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Malnutrition</i><br><i>Leucocytosis</i><br><i>Ascites</i>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                      |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                |                                                                                                                                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                  |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                |                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                     | 28b. Time of Injury<br>M                                                                                                                                                                          |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                                  | 28d. Describe how injury occurred                         |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                      |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     | 29c. License number<br>D42403                                                                                                                                                                     |                                |                                                                                                    | 29d. Date signed (Month, Day, Year)<br>6/21/2000                 |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>RAJ MATHUR 106 IRVING STREET NW, Washington DC                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |
| 31. Date filed (Month, Day, Year)<br>JUN 23 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                |                                                                                                                                                       | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                                    |                                                                  |                                                           |                                                      |                                                                                                                                                                                                          |                                                      |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23433

Amended Item#10a,10c per FHG785 7/25/2000 EW

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Minnie Brooks

2. Date of Death  
Month Day Year  
JUNE, 26, 2000

3. Time of Death

4:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Livingston Health Care Center

4b. City, Town, or Location of Death

Ft. Washington

4c. County of Death

Prince George's

5. Social Security Number

578-24-5486

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 12, 1915

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3204 Warder Street NW

10f. Zip Code

20010

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Janitor

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Macon SeaBrooks

18. Mother's Name (First, Middle, Maiden Surname)

Ella Golson

19a. Informant's Name/Relationship (Type, Print)

Sidney L. Brooks-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12817 Staton Court Upper Marlboro MD 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

7-1-00

20c. Location - City or Town, State

Landover Maryland

21. Signature of Funeral Service Licensee

S. E. A. M.

22. Name and Address of Facility

J.B. Jenkins Funeral Home  
7474 Landover RD Landover MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Sepsis

Due to (or as a consequence of):

Unknown

c.

Anemia

Due to (or as a consequence of):

Unknown

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Yada

29c. License number

D50454

29d. Date signed (Month, Day, Year)

JUNE, 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Yada

12021 Livingston Rd Ft. Washington MD 20744

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

B. Spack

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

per it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

copy 12 10

NOV 11 1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23434

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                        |                                                            |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>Agnes R. Bonk</b>                             |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>July 2, 2000</b>    |                                        |                                                            |                                                                                             | 3. Time of Death<br><b>8:45 am</b>                                                             |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Silver Spring</b> |                                        |                                                            |                                                                                             | 4c. County of Death<br><b>Montgomery</b>                                                       |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>220-60-0330</b>                                              |                                                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.             |                                        | 8. Date of Birth (Month, Day, Year)<br><b>May 11, 1914</b> |                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>DC</b>                                          |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Usual Residence of Decedent                                                                  |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location                                  |                                        |                                                            |                                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              | 10b. County<br><b>Anne Arundel</b>                                                                                                                |                                                                            | 10e. Street and Number<br><b>8247 Fairwood Drive</b>                                                                                                                                                                                                                                        |                                                              |                                        |                                                            | 10f. Zip Code<br><b>21122</b>                                                               |                                                                                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |  |                                                                                                                                                    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                         |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                               |                                                              |                                        |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                                                                                                                                                   |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>                                                                                                                                                               |                                                              |                                        |                                                            | 16b. Kind of Business/Industry<br><b>National Airport</b>                                   |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 17. Father's Name (First, Middle, Last)<br><b>Philip M. Riley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                                                   |                                                                            | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Nellie C. Beale</b>                                                                                                                                                                                                                  |                                                              |                                        |                                                            |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Bonk / Son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                                                                                                                                                   |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8247 Fairwood Drive, Pasadena, MD 21122</b>                                                                                                                                             |                                                              |                                        |                                                            |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                                                   |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cemetery</b>                                                                                                                                                                                 |                                                              |                                        |                                                            | Data<br><b>7/6/00</b>                                                                       |                                                                                                | 20c. Location - City or Town, State<br><b>Crownsville, MD</b>                                                                                                                                    |  |                                                                                                                                                    |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W, Silver Spring, MD 20901</b>                                                                                                                                                       |                                                              |                                        |                                                            |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiopulmonary Arrest</b><br>Due to (or as a consequence of):<br><b>b. Hypotension</b><br>Due to (or as a consequence of):<br><b>c. Severe blood loss from Lower Gastrointestinal bleed</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                                                                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                        |                                                            |                                                                                             |                                                                                                | Approximate Interval Between Onset and Death                                                                                                                                                     |  |                                                                                                                                                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anticoagulation after Hip surgery</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                        |                                                            |                                                                                             |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                        |                                                            |                                                                                             |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                                                   |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                              |                                        |                                                            |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                                                   |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                              | 28b. Time of Injury<br><b>M</b>        |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                                                                                                                                                                |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                                                   |                                                                            | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                              |                                        |                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                              |                                                                                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                        |                                                            |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              | 29c. License number<br><b>D 005148</b> |                                                            | 29d. Date signed (Month, Day, Year)<br><b>July 3, 2000</b>                                  |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Delroy P. Anglin, MD 12201 Plum Orchard Drive, Silver Spring, MD 20904</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                        |                                                            |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                              |                                        |                                                            |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ACV 17

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23435

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------|--|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph R. Carter</b>                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>July 8, 2000</b>    |                                                                                             |                                |                                                                                                | 3. Time of Death<br><b>6:30 pm</b>       |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><b>9618 Flower Avenue</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Silver Spring</b> |                                                                                             |                                |                                                                                                | 4c. County of Death<br><b>Montgomery</b> |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br><b>215-44-8642</b>                                             |                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.             |                                                                                             | If Under 1 Year<br>Months Days |                                                                                                | If Under 24 Hrs.<br>Hours Min.           |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 22, 1903</b> |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Usual Residence of Decedent                                                                 |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             | 10b. County<br><b>Montgomery</b>                                                                                                                  |                                                                            | 10c. City, Town or Location<br><b>Silver Spring</b>                                                                                                                                                                                                                                         |                                                              |                                                                                             |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 10e. Street and Number<br><b>9618 Flower Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                   |                                                                            | 10f. Zip Code<br><b>20901</b>                                                                                                                                                                                                                                                               |                                                              |                                                                                             |                                | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |                                                              |                                                                                             |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                                                   |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Off-set Pressman/ Printer</b>                                                                                                                                               |                                                              |                                                                                             |                                | 16b. Kind of Business/Industry<br><b>Federal Government</b>                                    |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph B. Carter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                                                                                                                                   |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Suzanna Roemer</b>                                                                                                                                                                                                           |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas J. Carter / Son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                                                                                   |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>214 Baden Street, Silver Spring, MD 20901</b>                                                                                                                                           |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                           |                                                                            | Date<br><b>7/11/00</b>                                                                                                                                                                                                                                                                      |                                                              | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>                                |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert Ramsey</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W, Silver Spring, MD 20901</b>                                                                                                                                                       |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Bladder Cancer</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                             |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            | Approximate interval Between Onset and Death<br><b>2 years</b>                                                                                                                                   |                                                                 |                                                                                                                                                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                 |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                                                                                   |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             | 28a. Date of Injury (Month, Day Year)                                                                                                             |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                             |                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                | 28d. Describe how injury occurred                                                              |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             |                                                                                                                                                   |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                           |                                                                                             |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 29b. Signature and title of certifier<br><i>Leonard Bloom</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                                                                                                                   |                                                                            | 29c. License number<br><b>739918</b>                                                                                                                                                                                                                                                        |                                                              |                                                                                             |                                | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                                    |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Leonard S. Bloom, MD 2730 University Blvd., West #516, Wheaton, MD 20902</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br><i>Debra B. Sparks</i>                                                                                                                                                                                                                                         |                                                              |                                                                                             |                                |                                                                                                |                                          |  |                                                            |                                                                                                                                                                                                  |                                                                 |                                                                                                                                                    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



00 58:32

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23436

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alfredo B. Castro, Sr.

2. Date of Death

Month Day Year  
July 11, 2000

3. Time of Death

8:10 pm

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

213-84-9588

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 16, 1914

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4313 Knott Street

10f. Zip Code

20705

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Sign Painter

17. Father's Name (First, Middle, Last)

Victoriano Castro

18. Mother's Name (First, Middle, Maiden Surname)

Gregoria Brillantes

19a. Informant's Name/Relationship (Type, Print)

Isreal H. Castro / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16104 Kenny Road, Laurel, MD 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery 2000

Date

7/14

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

James S. Doda

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

G. Chablani

29c. License number

D 42578

29d. Date signed (Month, Day, Year)

July 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Chablani, MD 11119 Rockville Pike #610, Rockville, MD 20852

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23437

AMENDED ITEM #20b per fh G791 010501 SS

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Antonio Ciccarello

2. Date of Death

Month Day Year  
July 7, 2000

3. Time of Death

0016

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

578 56 9456

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 12, 1940

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

128 Lazy Hollow Drive

10f. Zip Code

20878

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tailor

16b. Kind of Business/Industry

Tailor Shop

17. Father's Name (First, Middle, Last)

Nicola Ciccarello

18. Mother's Name (First, Middle, Maiden Surname)

Caterina Cavallo

19a. Informant's Name/Relationship (Type, Print)

Giuseppe Ciccarello/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8301 Aqueduct Road, Potomac, MD 20854

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

July 7, 2000

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death

48 Hours

Due to (or as a consequence of):

e.

Pneumonia

7 Days

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Cardiomyopathy

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23308

29d. Date signed (Month, Day, Year)

July 7, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Victor M. Priego, M.D., 6410 Rockledge Drive, #625, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100-100



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23438

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br>Mary Ann E. Watkins Claxton                          |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 2. Date of Death<br>Month Day Year<br>July 5, 2000                                                                                                                                               |                                                                                                                                                                                                          | 3. Time of Death<br>12:00PM                                                          |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br>9707 Old Georgetown Road #1501 |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 4b. City, Town, or Location of Death<br>Bethesda                                                                                                                                                 |                                                                                                                                                                                                          | 4c. County of Death<br>Montgomery                                                    |                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br>410-22-5233                                                         |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |                                                                                                                        | 7. Age (In yrs. last birthday)<br>79 Yrs.                                                                                                                                                        |                                                                                                                                                                                                          | 8. Date of Birth (Month, Day, Year)<br>Sept. 12, 1920                                |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | If Under 1 Year<br>Months Days                                                                                                                                                                   |                                                                                                                                                                                                          | If Under 24 Hrs.<br>Hours Min.                                                       |                                                                  |  |
| 9. Birthplace (State or Foreign Country)<br>Tennessee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |  | 10b. County<br>Montgomery                                                                                                                                                                                                                                                                               |                                                                                                                        |                                                                                                                                                                                                  | 10c. City, Town or Location<br>Bethesda                                                                                                                                                                  |                                                                                      |                                                                  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 10e. Street and Number<br>9707 Old Georgetown Road #1501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br>20817                                                                                                 |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br>United States                                                                                                                                                           |                                                                                      |                                                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII                                                                                                                                              |                                                                                                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                          |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |                                                                                                                                                                                                  |                                                                                                                                                                                                          | 16b. Kind of Business/Industry<br>Own Home                                           |                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br>James Morgan Watkins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 18. Mother's Name (First, Middle, Maiden Surname)<br>Isabelle Gettys                                                                                                                             |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Isabelle Claxton/Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8010 Winston Road, Philadelphia, Pennsylvania 19118                                             |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc.                                                                                                                                                                                                  |                                                                                                                        |                                                                                                                                                                                                  | Date<br>July 7, 2000                                                                                                                                                                                     |                                                                                      | 20c. Location - City or Town, State<br>Bethesda, Maryland        |  |
| 21. Signature of Funeral Service Licensee<br> MO1126                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue,<br>Bethesda, Maryland 20814-3501                                      |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Ovarian Cancer<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| Approximate Interval Between Onset and Death<br>9 Months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Gout<br>Coronary Artery Bypass Graft-Three Vessels<br>Alcohol Dependence                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                                                      |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                                                      |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                                                      |                                                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                        | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                                                                                                                                                                          | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                        |                                                                                                                                                                                                  | 28d. Describe how injury occurred                                                                                                                                                                        |                                                                                      |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 29c. License number<br>MD D43254                                                                                                                                                                 |                                                                                                                                                                                                          | 29d. Date signed (Month, Day, Year)<br>July 6, 2000                                  |                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Lauren E. Cosgrove, M.D. 6111 Executive Boulevard, Rockville, Maryland 20852                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |  | 32. Registrar's Signature<br>                                                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                                                                          |                                                                                      |                                                                  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23439

## Certificate of Death

Reg. No.

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                    |                                   |                                                       |                                                  |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------|--------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Anna Louise Carter Cobb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  | 2. Date of Death<br>Month Day Year<br>July 7, 2000                                                                                                                                                                                                                                                      |  |                                                                                                    | 3. Time of Death<br>4:10 PM       |                                                       |                                                  |
|                                                                      | 4a. Facility Name (If not Institution, give street and number)<br>Brighton Gardens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  | 4b. City, Town, or Location of Death<br>Rockville                                                                                                                                                                                                                                                       |  |                                                                                                    | 4c. County of Death<br>Montgomery |                                                       |                                                  |
| Funeral<br>Director                                                  | 5. Social Security Number<br>213-50-9329                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br>88 Yrs.                                                                                                                                                        |  | If Under 1 Year<br>Months Days                                                                                                                                                                                                                                                                          |  | If Under 24 Hrs.<br>Hours Min.                                                                     |                                   | 8. Date of Birth (Month, Day, Year)<br>March 13, 1912 | 9. Birthplace (State or Foreign Country)<br>Utah |
|                                                                      | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                    |                                   |                                                       |                                                  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. County<br>Montgomery                                                                                                                             |  | 10c. City, Town or Location<br>Rockville                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                   |                                                       |                                                  |
|                                                                      | 10e. Street and Number<br>5550 Tuckerman Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  | 10f. Zip Code<br>20852                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 10g. Citizen of What Country?<br>United States                                                     |                                   |                                                       |                                                  |
|                                                                      | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                                                                                                                                                                                                                                         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                   |                                                       |                                                  |
|                                                                      | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4or 5+)<br>- 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 16b. Kind of Business/Industry<br>Own Home                                                         |                                   |                                                       |                                                  |
|                                                                      | 17. Father's Name (First, Middle, Last)<br>William Henry Carter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ellice Adelaide McClenahan                                                                                                                                                                                                                         |  |                                                                                                    |                                   |                                                       |                                                  |
| To Be Completed by Funeral Director                                  | 19a. Informant's Name/Relationship (Type, Print)<br>John L. Cobb/ Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3420 Forest Wood Drive, Brookeville, MD 20833                                                                                                                                                          |  |                                                                                                    |                                   |                                                       |                                                  |
|                                                                      | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parklawn Memorial Park                                                                                                 |  | Date<br>July 18, 2000                                                                                                                                                                                                                                                                                   |  | 20c. Location - City or Town, State<br>Rockville, Maryland                                         |                                   |                                                       |                                                  |
|                                                                      | 21. Signature of Funeral Service Licensee<br> M00689                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue,<br>Bethesda, Maryland 20814-3501                                                                                                                                              |  |                                                                                                    |                                   |                                                       |                                                  |
|                                                                      | 23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Atherosclerotic Heart Disease</u> years<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                    |                                   |                                                       |                                                  |
|                                                                      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><u>Congestive Heart Failure</u><br><br><u>Atrial Fibrillation</u>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                    |                                   |                                                       |                                                  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                                                                                    |                                   |                                                       |                                                  |
|                                                                      | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                 |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |  | 28b. Time of Injury<br>M                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                         |  | 28d. Describe how injury occurred                                                                  |                                   |                                                       |                                                  |
|                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                                    |                                   |                                                       |                                                  |
|                                                                      | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                    |                                   |                                                       |                                                  |
|                                                                      | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  | 29c. License number<br>D33357                                                                                                                                                                                                                                                                           |  | 29d. Date signed (Month, Day, Year)<br>July 10, 2000                                               |                                   |                                                       |                                                  |
| State Registrar                                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Lee Jonathan Musher, M.D. 5530 Wisconsin Avenue, #1045, Chevy Chase, MD 20815                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                    |                                   |                                                       |                                                  |
|                                                                      | 31. Date filed (Month, Day, Year)<br>JUL 12 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |  | 32. Registrar's Signature<br>                                                                                |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                    |                                   |                                                       |                                                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23440

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELWOOD B. COLE, JR.

2. Date of Death

JULY 8, 2000

3. Time of Death

10:47 PM

4a. Facility Name (If not Institution, give street and number)

17705 QUEEN ELIZABETH DRIVE

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579 12 9016

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 31, 1923

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

OLNEY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17705 QUEEN ELIZABETH DRIVE

10f. Zip Code

20832

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELECTRICAL ENGINEER

16b. Kind of Business/Industry

AEROSPACE

17. Father's Name (First, Middle, Last)

ELWOOD B. COLE

18. Mother's Name (First, Middle, Maiden Surname)

RUTH - HAYS

19a. Informant's Name/Relationship (Type, Print)

ARLENE A. COLE, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17705 QUEEN ELIZABETH DRIVE, OLNEY, MD. 20832

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY

Date

7/10/00

20c. Location - City or Town, State

ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME  
P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33688

29d. Date signed (Month, Day, Year)

July 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Miller, MD 1801 Pine Philip Dr. Olney, MD 20832

31. Date filed (Month, Day, Year)

JUL 11 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1511

01497

[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. The text is arranged in several paragraphs and appears to be a formal document or report.]

## Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2

State Registrar



1-1-77



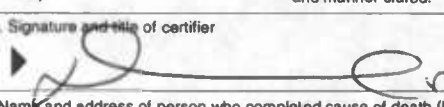
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23442

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                            |                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                            |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br>James A. Counselis                             |                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                            | 2. Date of Death<br>Month Day Year<br>July 12, 2000   |                                                                                      |                                                      |                                                                                                    | 3. Time of Death<br>4:15 A.M.                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br>Forest Glen Nursing Home |                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                            | 4b. City, Town, or Location of Death<br>Silver Spring |                                                                                      |                                                      |                                                                                                    | 4c. County of Death<br>Montgomery                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br>341-12-0011                                                   |                                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                            | 7. Age (In yrs. last birthday)<br>78 Yrs.             |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Aug. 26, 1921 |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Illinois |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Usual Residence of Decedent                                                                |                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                            |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                            | 10b. County<br>Montgomery                                                                                                                                         |                                                                            | 10c. City, Town or Location<br>Silver Spring                                                                                                                                                                                                                                                               |                                                       |                                                                                      |                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                      |  |
| 10e. Street and Number<br>10100 New Hampshire Ave., #206                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            |                                                                                                                                                                   |                                                                            | 10f. Zip Code<br>20903                                                                                                                                                                                                                                                                                     |                                                       |                                                                                      |                                                      | 10g. Citizen of What Country?<br>USA                                                               |                                                      |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                              |                                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give WW II Year or Dates: WW II |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                          |                                                       |                                                                                      |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 4                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                            |                                                                                                                                                                   |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Accountant                                                                                                                                                                                    |                                                       |                                                                                      |                                                      | 16b. Kind of Business/Industry<br>Taxes                                                            |                                                      |  |
| 17. Father's Name (First, Middle, Last)<br>Demetrous Counselis                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                                                                                                                                                                   |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Koula (Unobtainable)                                                                                                                                                                                                                                  |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mary Counselis / Wife                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                                                                                                                                                                   |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10100 New Hampshire Ave., #206, Silver Spring, MD 20903                                                                                                                                                   |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                     |                                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Crematory                                                                  |                                                                            | Date<br>07/13/00                                                                                                                                                                                                                                                                                           |                                                       | 20c. Location - City or Town, State<br>Brentwood, Maryland                           |                                                      |                                                                                                    |                                                      |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                            |                                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904                                                                                                                                                                              |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial infarction<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>sudden |                                                                                            |                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                            |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dementia<br>Peripheral vascular disease                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                            |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            |                                                                                                                                                                   |                                                                            | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                           |                                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                             |                                                                            | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                   |                                                       | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how Injury occurred                                                                  |                                                      |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                       |                                                                                            |                                                                                                                                                                   |                                                                            | 29b. Signature and title of certifier<br>                                                                                                                                                                               |                                                       | 29c. License number<br>000053528                                                     |                                                      | 29d. Date signed (Month, Day, Year)<br>July 12, 2000                                               |                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Daphna Henkin, M.D. 2309 Shorefield Road, Wheaton, Maryland 20902                                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                            |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |                                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                          |                                                       |                                                                                      |                                                      |                                                                                                    |                                                      |  |

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23443

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Constance Frances Cunningham

2. Date of Death

Month Day Year  
July 12, 2000

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

11712 Castlewood Court

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

039-01-8543

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
November 30, 1921

9. Birthplace (State or Foreign Country)

Rhode Island

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11712 Castlewood Court

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Hardware Store

17. Father's Name (First, Middle, Last)

Zephyr Langlois

18. Mother's Name (First, Middle, Maiden Surname)

Albina Belhumeur

19a. Informant's Name/Relationship (Type, Print)

Jill C. Cunningham/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11712 Castlewood Court, Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

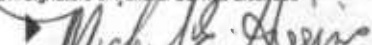
Data

July 15,  
2000

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee



M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Alzheimer's Disease

Approximate  
Interval Between  
Onset and Death

Years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury


M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D0038781

29d. Date signed (Month, Day, Year)

July 13, 2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Michael J. Grady, M.D., 4910 Massachusetts Avenue, N.W.#210, Washington, D.C. 20016

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature



ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

00 23444

## Certificate of Death

Reg. No.

|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                        |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Thomas W. Curtis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                        |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>July 4, 2000                                                                                                                                                |  |                                                                                      |  | 3. Time of Death<br>3:43 AM                                                                                                                                                                              |  |
|                                                  | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Silver Spring                                                                                                                                             |  |                                                                                      |  | 4c. County of Death<br>Montgomery                                                                                                                                                                        |  |
| Funeral<br>Director                              | 5. Social Security Number<br>578-09-3746                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                        | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>84 Yrs.                                                                                                                                                         |  | 8. Date of Birth (Month, Day, Year)<br>June 30, 1916                                 |  | 9. Birthplace (State or Foreign Country)<br>Virginia                                                                                                                                                     |  |
|                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director              | 10a. State<br>Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        | 10b. County<br>Loudoun                                                                                                                                                                                                                                                                                  |  | 10c. City, Town or Location<br>Potomac Falls                                                                                                                                                      |  |                                                                                      |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |  |
|                                                  | 10e. Street and Number<br>47095 South Hampton Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                        |                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br>20165                                                                                                                                                                            |  | 10g. Citizen of What Country?<br>United States                                       |  |                                                                                                                                                                                                          |  |
|                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                                                                                                                         |  |
|                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                        |                                                                                                                                                                                                                                                                                                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Engineer                                                                             |  |                                                                                      |  | 16b. Kind of Business/Industry<br>U.S. Government                                                                                                                                                        |  |
|                                                  | 17. Father's Name (First, Middle, Last)<br>Theodore W. Curtis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                        |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lillian Williams                                                                                                                             |  |                                                                                      |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner    | 19a. Informant's Name/Relationship (Type, Print)<br>Ingrid Curtis, daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3041 Weldon Avenue, Los Angeles, California 90065                                                |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                          |                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory                                                                                                                                                                                                          |  | Data<br>7/6/00                                                                                                                                                                                    |  | 20c. Location - City or Town, State<br>Beltsville, MD                                |  |                                                                                                                                                                                                          |  |
|                                                  | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>McGuire Funeral Service, Inc.<br>7400 Georgia Ave. N.W., Washington, D.C.                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br><br>Respiratory Failure<br>Due to (or as a consequence of):<br><br>Cerebrovascular Accident<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. b. c. d. |                                        |                                                                                                                                                                                                                                                                                                         |  | Approximate Interval Between Onset and Death<br>1 day<br>2 months                                                                                                                                 |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| State Registrar                                  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                      |  |                                                                                                                                                                                                          |  |
|                                                  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                |                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M                                                                                                                                                                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                                                                                                                                                        |  |
|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                        | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  |                                                                                                                                                                                                   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |                                                                                                                                                                                                          |  |
|                                                  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                         |                                        | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  | 29c. License number<br>D24886                                                        |  | 29d. Date signed (Month, Day, Year)<br>July 4, 2000                                                                                                                                                      |  |
|                                                  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Mark Eig, M.D., 10801 Lockwood Drive, Silver Spring, Maryland 20901                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 2000 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 32. Registrar's Signature<br>B. Sparks |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 00 23445

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Judith Cuthie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          | 2. Date of Death<br>Month Day Year<br>July 10, 2000                                                                                                                                              |                                                                                                    | 3. Time of Death<br>8:45 am                                                                                                                                                                              |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>2129 Kimrick Place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          | 4b. City, Town, or Location of Death<br>Lutherville                                                                                                                                              |                                                                                                    | 4c. County of Death<br>Baltimore                                                                                                                                                                         |  |
| Funeral<br>Director                           | 5. Social Security Number<br>214-74-3072                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>57 Yrs.                                                                                                                                                                                                                                                               | If Under 1 Year<br>Months Days                                                                                                           | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   | 8. Date of Birth (Month, Day, Year)<br>Aug. 9, 1942                                                | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                     |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10b. County<br>Baltimore                                                       | 10c. City, Town or Location<br>Lutherville                                                                                                                                                                                                                                                              |                                                                                                                                          |                                                                                                                                                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                                                                                          |  |
|                                               | 10e. Street and Number<br>2129 Kimrick Place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br>21093                                                                                                                   |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br>United States                                                     |                                                                                                                                                                                                          |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Instructor, Asst. Prof.                                                                                                                                                                    |                                                                                                                                          | 16b. Kind of Business/Industry<br>Johns Hopkins Univ.                                                                                                                                            |                                                                                                    |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>John Michael Novotny                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          | 18. Mother's Name (First, Middle, Maiden Surname)<br>Marie Timko                                                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br>David Cuthie - husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2129 Kimrick Pl., Lutherville, MD 21093 |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
|                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                  |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory                                                                                                                                                                                                          |                                                                                                                                          | Date<br>7/11/00                                                                                                                                                                                  |                                                                                                    | 20c. Location - City or Town, State<br>Beltsville, MD                                                                                                                                                    |  |
|                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | 22. Name and Address of Facility<br>CAFA, Stephen D. Lohrmann, P.A.<br>8717 Green Pastures Dr., Towson, MD 21286                                                                                                                                                                                        |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Non-small cell lung cancer<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    | Approximate Interval Between Onset and Death<br>6 months                                                                                                                                                 |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                   |  |
|                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                        |                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                          | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                          | 28d. Describe how injury occurred                                                                                                                                                                |                                                                                                    |                                                                                                                                                                                                          |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
|                                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                 |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
| State<br>Registrar                            | 29b. Signature and title of certifier<br><br>DIRECTOR, MEDICAL ONCOLOGY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          | 29c. License number<br>D23675                                                                                                                                                                    |                                                                                                    | 29d. Date signed (Month, Day, Year)<br>7-10-00                                                                                                                                                           |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ROSS DONE-HOWER, MD Johns Hopkins Oncology Center Baltimore, MD 21231                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
|                                               | 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                                          |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 23446

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br>Warren Edward Childress, Sr.              |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 2. Date of Death<br>Month Day Year<br>July 15 2000                                                                                                                                           |                                         |                                                                                  |                                                                                                | 3. Time of Death<br>02:45AM                          |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br>10704 Westwood Lane |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 4b. City, Town, or Location of Death<br>Waldorf                                                                                                                                              |                                         |                                                                                  |                                                                                                | 4c. County of Death<br>Charles                       |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br>223-09-4521                                              |                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                               | 7. Age (In yrs. last birthday)<br>89 Yrs.                                                                                                                                                    |                                         | 8. Date of Birth (Month, Day, Year)<br>April 15, 1911                            |                                                                                                | 9. Birthplace (State or Foreign Country)<br>Virginia |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Usual Residence of Decedent                                                           |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       | 10b. County<br>Charles |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br>Waldorf                                                                                        |                                                                                                                                                                                              |                                         |                                                                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                      |                                                                                                                                                                                                  |  |
| 10e. Street and Number<br>10704 Westwood Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                        |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br>20601                                                                                                        |                                                                                                                                                                                              | 10g. Citizen of What Country?<br>U.S.A. |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1944-46                                                                                                                                   |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                         |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |                                                      |                                                                                                                                                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                        |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Graphic Designer |                                                                                                                                                                                              |                                         | 16b. Kind of Business/Industry<br>Organization of American States (OAS)          |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br>Arthur L. Childress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dottie May Welsh                                                                                                                        |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy Louise Childress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10704 Westwood Lane, Waldorf, Maryland 20601                                                |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Trinity Memorial Gardens                                                                                                                                                                                          |                                                                                                                               |                                                                                                                                                                                              | Date<br>7/18/2000                       |                                                                                  | 20c. Location - City or Town, State<br>Waldorf, Maryland                                       |                                                      |                                                                                                                                                                                                  |  |
| 21. Signature of Funeral Service Director<br>John P. Knisley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                        | 22. Name and Address of Facility<br>The Hunt Funeral Home, Inc., Post Office Box 156, Waldorf, Maryland 20604-0156                                                                                                                                                                          |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Parkinson's Disease End-Stage<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                        | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                              |                                                                                       |                        | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                               | 28b. Time of Injury<br>M                                                                                                                                                                     |                                         | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                        | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                               |                                                                                                                                                                                              |                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                         |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br>M. Mathur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 29c. License number<br>D28352                                                                                                                                                                |                                         |                                                                                  | 29d. Date signed (Month, Day, Year)<br>July 17, 2000                                           |                                                      |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                                                              |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       |                        |                                                                                                                                                                                                                                                                                             |                                                                                                                               | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                       |                                         |                                                                                  |                                                                                                |                                                      |                                                                                                                                                                                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

00 23447

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>JANE de Moss CHRISTOPHER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                             |                                      | 2. Date of Death<br>Month Day Year<br><b>JULY 11, 2000</b>                                                                                                                                    |                                                                                                | 3. Time of Death<br><b>3:00 AM</b>                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>200 POTOMAC COURT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                             |                                      | 4b. City, Town, or Location of Death<br><b>SYKESVILLE</b>                                                                                                                                     |                                                                                                | 4c. County of Death<br><b>CARROLL</b>                                                                                                                                                            |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>212-09-2754</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>8/9/1918</b>                                         | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>CARROLL</b>                                              | 10c. City, Town or Location<br><b>SYKESVILLE</b>                                                                                                                                                                                                                                            |                                      |                                                                                                                                                                                               | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>200 POTOMAC COURT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>21784</b>        |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LEGAL SECRETARY</b>                                                                                                                                                         |                                      |                                                                                                                                                                                               | 16b. Kind of Business/Industry<br><b>BROADCASTING</b>                                          |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>ERNEST de Moss</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY Robinson</b>                                                                                                                     |                                                                                                |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 19a. Informant's Name/Relationship (Type, Print)<br><b>DEBRA C. FLETCHER -DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                             |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 POTOMAC COURT, SYKESVILLE, MD. 21784</b>                                              |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>                                                                                                                                                                                            |                                      | Date<br><b>7/12/00</b>                                                                                                                                                                        |                                                                                                | 20c. Location - City or Town, State<br><b>BALTIMORE, MD.</b>                                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                             |                                      | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME<br/>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>                                                                                  |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. adenocarcinoma of the rectum</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Approximate Interval Between Onset and Death<br><b>five months</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                      | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                   |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             | 29c. License number<br><b>D17040</b> |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>                                    |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Howard G. Lanham, M.D. 215 Washington Hgts Med'l Ctr, Westminster, MD 21157</b>                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 32. Registrar's Signature<br>                                              |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23448

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret M. Craig</b>                                                 |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               | 2. Date of Death<br>Month Day Year<br><b>July 10, 2000</b> |                                                                                             |                                                            |                                                                                                | 3. Time of Death<br><b>1:25 P.M.</b>                             |                                                                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br><b>Millennium Health &amp; Rehabilitation Ctr.</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>Edgewater</b>   |                                                                                             |                                                            |                                                                                                | 4c. County of Death<br><b>Anne Arundel</b>                       |                                                                                                                                                                                                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><b>235-66-5672</b>                                                                      |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.           |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 5, 1911</b> |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |                                                                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                      | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                          |                                                                            | 10c. City, Town or Location<br><b>Edgewater</b>                                                                                                                                               |                                                            |                                                                                             |                                                            | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                  |                                                                                                                                                                                                             |  |
| 10a. Street and Number<br><b>113 Claiborne Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 10f. Zip Code<br><b>21037</b>                                                                                                                                                                 |                                                            |                                                                                             |                                                            | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                  |                                                                                                                                                                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                            |                                                                                             |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                                  |                                                                                                                                                                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                 |                                                            |                                                                                             |                                                            | 16b. Kind of Business/Industry<br><b>Home</b>                                                  |                                                                  |                                                                                                                                                                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Vaughan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie Fogus</b>                                                                                                                      |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charlotte L. Mitchell/ Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>113 Claiborne Road Edgewater, Maryland 21037</b>                                          |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Meml. Park</b>                                                                                                                                                                                      |                                                                            | 20c. Date<br><b>7-13-00</b>                                                                                                                                                                   |                                                            | 20d. Location - City or Town, State<br><b>London, WV</b>                                    |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home<br/>2973 Solomons Island Rd. Edgewater, MD 21037</b>                                                                      |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>End stage cardiovascular pathology</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last<br><b>Alcohol</b><br><b>Dementia</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  | Approximate Interval Between Onset and Death<br><b>Unknown</b>                                                                                                                                              |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alcohol</b><br><b>Dementia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                            | 28d. Describe how injury occurred                                                              |                                                                  |                                                                                                                                                                                                             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Pikesville, MD</b>                                                                                         |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                        |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 29b. Signature and title of certifier<br><br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 29c. License number<br><b>027564</b>                                                                                                                                                          |                                                            | 29d. Date signed (Month, Day, Year)<br><b>7/11/00</b>                                       |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Allen DeHleman 1838 Greene Tree Rd #300</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                            |                                                                                                                                                                                               |                                                            |                                                                                             |                                                            |                                                                                                |                                                                  |                                                                                                                                                                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene 00 23449

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gerardo Capezio

2. Date of Death

07 05 2000

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

127-30-1893

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 3, 1919

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

107 S. Cherry Grove Avenue

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tailor

16b. Kind of Business/Industry

U.S. Naval Academy

17. Father's Name (First, Middle, Last)

Anthony Capezio

18. Mother's Name (First, Middle, Maiden Surname)

Felicia Trotta

19a. Informant's Name/Relationship (Type, Print)

Rosa Capezio / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 S. Cherry Grove Ave. Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Memorial Gardens

Date

7/13/00

20c. Location - City or Town, State

Annapolis, Maryland

21. Signature of Funeral Service Licensee

E. B. Powell

22. Name and Address of Facility John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester Street Annapolis, Maryland 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Cerebral Vascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 d

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

Nancy J. Heisel MD

29d. License number

D0055458

29e. Date signed (Month, Day, Year)

07/05/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NANCY J. HEISEL 64 Franklin, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JUL 11 2000

32. Registrar's Signature

B. Pratt

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23450

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Carruthers

2. Date of Death

July 7 2000

3. Time of Death

8 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice at Mercy Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

219-10-2130

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec 5, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7841 Americana Circle Apt T2

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Paul T. Stionoff

18. Mother's Name (First, Middle, Maiden Surname)

Margaret McCay

19a. Informant's Name/Relationship (Type, Print)

Mary Anne Slaughter/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2311 229 Street, Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

July 8

2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco &amp; Sons, P.A. Severna Park Funeral Home

495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic small cell lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

uterine cancer

Peptic Ulcer disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40854

29d. Date signed (Month, Day, Year)

7/7/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 11 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23451

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Mae Carman</b>                                                                                                                                                                                                                                                                                                                                                   |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               | 2. Date of Death<br>Month <b>July</b> Day <b>4</b> , Year <b>2000</b>                                                                          |                                                                                                                                                                                                  | 3. Time of Death<br><b>11:00 am</b>        |                                                             |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Heartlands Assisted Living</b>                                                                                                                                                                                                                                                                                                                       |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>Severna Park</b>                                                                                    |                                                                                                                                                                                                  | 4c. County of Death<br><b>Anne Arundel</b> |                                                             |
| Funeral<br>Director                           | 5. Social Security Number<br><b>382-40-4977</b>                                                                                                                                                                                                                                                                                                                                                                           |                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                | If Under 24 Hrs.<br>Hours Min.                                                                                                                 | 8. Date of Birth (Month, Day, Year)<br><b>Jan 15, 1909</b>                                                                                                                                       |                                            | 9. Birthplace (State or Foreign Country)<br><b>Michigan</b> |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>Anne Arundel</b> |                                                                                                                                                                                                                                                                                                                    | 10c. City, Town or Location<br><b>Annapolis</b>  |                                                                                                                                                                                               |                                                                                                                                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                            |                                                             |
|                                               | 10e. Street and Number<br><b>1425 Harmony Lane</b>                                                                                                                                                                                                                                                                                                                                                                        |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  | 10f. Zip Code<br><b>21401</b>                                                                                                                                                                 |                                                                                                                                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                            |                                                             |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                  |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |                                            |                                                             |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                               |                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>                                                                                                                                                                                        |                                                  |                                                                                                                                                                                               | 16b. Kind of Business/Industry<br><b>Education</b>                                                                                             |                                                                                                                                                                                                  |                                            |                                                             |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Leroy Lester Parsons</b>                                                                                                                                                                                                                                                                                                                                                    |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Helen Jacob</b>                                                                    |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol Carman/ daughter</b>                                                                                                                                                                                                                                                                                                                                         |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1425 Harmony Lane, Annapolis, MD 21401</b> |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                                                                                                                                                                                   |                                                  | Date<br><b>July 6 2000</b>                                                                                                                                                                    | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                                                                    |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | 21. Signature of Funeral Service Licensee<br><i>James E. Barranco</i>                                                                                                                                                                                                                                                                                                                                                     |                                    | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park</b><br><b>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>                                                                                                                                                                          |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
| Physician<br>/Medical<br>Examiner             | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                  |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction minutes</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                            |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Coronary artery disease years</b><br>Due to (or as a consequence of):                                                                                                                                                                                 |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | c. Due to (or as a consequence of):<br>d.                                                                                                                                                                                                                                                                                                                                                                                 |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                            |                                                             |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                            |                                                             |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |                                            |                                                             |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>assisted living</b> |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                    | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                             |                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                            |                                                             |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                                                                               |                                                                                                                                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                            |                                                             |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | 29b. Signature and title of certifier<br><i>James Chaconas</i>                                                                                                                                                                                                                                                                                                                                                            |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  | 29c. License number<br><b>D16964</b>                                                                                                                                                          |                                                                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>7/5/00</b>                                                                                                                                             |                                            |                                                             |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James Chaconas 1509 Ritchie Hwy Arnold, MD 21012</b>                                                                                                                                                                                                                                                                           |                                    |                                                                                                                                                                                                                                                                                                                    |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |
|                                               | 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                    | 32. Registrar's Signature<br><i>James P. Spotts</i>                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                                                                  |                                            |                                                             |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

JUL 8 0 00 PM '68

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23452

## Certificate of Death

Reg. No.

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>JAMES A. CAYWOOD III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       | 2. Date of Death<br>Month Day Year<br>July 10 2000                                                                                                                                            |  |                                                                                  |                                                                  | 3. Time of Death<br>21:37pm                                                                    |  |                                                                                                                                                                                                  |  |
|                                                                      | 4a. Facility Name (If not institution, give street and number)<br>FREDERICK MEMORIAL HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       | 4b. City, Town, or Location of Death<br>FREDERICK                                                                                                                                             |  |                                                                                  |                                                                  | 4c. County of Death<br>FREDERICK                                                               |  |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                  | 5. Social Security Number<br>401-22-6404                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                       | 7. Age (In yrs. last birthday)<br>77 Yrs.                                                                                                                                                     |  | 8. Date of Birth (Month, Day, Year)<br>JAN 28 1923                               |                                                                  | 9. Birthplace (State or Foreign Country)<br>KY                                                 |  |                                                                                                                                                                                                  |  |
|                                                                      | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                       | 10b. County<br>FREDERICK                                                                                                                                                                                                                                                                    |                                                                                                                       | 10c. City, Town or Location<br>FREDERICK                                                                                                                                                      |  |                                                                                  |                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |                                                                                                                                                                                                  |  |
|                                                                      | 10e. Street and Number<br>2483 FIVE SHILLINGS RD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       | 10f. Zip Code<br>21701                                                                                                                                                                        |  | 10g. Citizen of What Country?<br>U.S.A.                                          |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944-<br>If Yes, Give Year or Dates: 1946                                                                                                                                |                                                                                                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>ENGINEER |                                                                                                                                                                                               |  | 16b. Kind of Business/Industry<br>TRANSPORTATION                                 |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 17. Father's Name (First, Middle, Last)<br>JAMES A. CAYWOOD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY VIOLA CRAWFORD                                                                                                                      |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                  | 19a. Informant's Name/Relationship (Type, Print)<br>CAROL CAYWOOD/SPOUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2483 FIVE SHILLINGS RD., FREDERICK, MD 21701                                                 |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                         |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>HIGHLAND CEMETERY                                                                                                                                                                                                 |                                                                                                                       | 20c. Date<br>7/15                                                                                                                                                                             |  | 20d. Location - City or Town, State<br>FORT MITCHELL, KY                         |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       | 22. Name and Address of Facility<br>HILTON FUNERAL HOME<br>BOX 86, BARNESVILLE, MD 20838                                                                                                      |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Lung Cancer<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  | Approximate Interval Between Onset and Death<br>1 year                                                                                                                                           |  |
|                                                                      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                       | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                 |                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                       | 28b. Time of Injury<br>M                                                                                                                                                                      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                              |  |                                                                                                                                                                                                  |  |
|                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                                                      | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                  |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
| State Registrar                                                      | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       | 29c. License number<br>11506                                                                                                                                                                  |  |                                                                                  |                                                                  | 29d. Date signed (Month, Day, Year)<br>July 11, 2000                                           |  |                                                                                                                                                                                                  |  |
|                                                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Frederick P. Smith 5401 Western Ave NW Washington DC 20015                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 13 2000                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 32. Registrar's Signature<br>P. Smith |                                                                                                                                                                                                                                                                                             |                                                                                                                       |                                                                                                                                                                                               |  |                                                                                  |                                                                  |                                                                                                |  |                                                                                                                                                                                                  |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 23453

Amended Item#8 perFHG785 7/25/2000 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Warner Black Castelow

2. Date of Death

Month 6 - Day 25 - Year 2000

3. Time of Death

6:38 PM

4e. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

217-14-3757

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8-16-1914

9. Birthplace (State or Foreign Country)

Elkton, Md.

Usual Residence of Decedent

10a. State

Delaware

10b. County

New Castle

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

608 Churchtown Rd

10f. Zip Code

19709

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

—

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Auto Industry

17. Father's Name (First, Middle, Last)

William Castelow

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Taylor

19e. Informant's Name/Relationship (Type, Print)

Christina C. Pleasanton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39006 Church St, Greenbackville, Va.

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Crematory

Date

6-29-00

20c. Location - City or Town, State

Dover, De.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Daniels &amp; Hutchison

212 N. Broad St  
Middletown, De

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 wk

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Uro sepsis

Due to (or as a consequence of):

7-10 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

advanced alzheimers dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D 94102

29d. Date signed (Month, Day, Year)

6/27/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William F. Renzulli, MD 901 Warburton Rd, Elkton, Md.

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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AMEND#5 16A&B PER K.B. G786 8-4-2000  
Amended item #19a, per FH, TCHD, 7-3-00, SHS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23454

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

COLLETTE CHEEMOANDIA CUSTIS

2. Date of Death  
Month Day Year  
JUNE 30 20003. Time of Death  
1505

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

NONE

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

JUNE 30, 2000

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

ST. MICHAELS

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

234 A. NORTH ST

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INFANT

16b. Kind of Business/Industry

INFANT

17. Father's Name (First, Middle, Last)

CRAIG T. CUSTIS, SR

18. Mother's Name (First, Middle, Maiden Surname)

RUTH ELAINE KELLUM

19a. Informant's Name/Relationship (Type, Print)

Ruth E. Kellum/mother  
RUTH E. KELLUM/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

234A NORTH ST. ST. MICHAELS, MD 21663

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CTR 7-03-00 STEVENSVILLE, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph M. Ostrowski

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA  
200 S. HARRISON ST EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CARDIORESPIRATORY ARREST

Due to (or as a consequence of):

2 HOURS

b. EXTREME PREMATURITY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Fayette Engstrom M.D.

29c. License number

D41160

29d. Date signed (Month, Day, Year)

JUNE 30, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FAYETTE ENGSTROM, M.D. 8579 COMMERCE DRIVE #104 EASTON, MD 21601

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23455

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br>Marie Frances Dixon                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    | 2. Date of Death<br>Month Day Year<br>July 10 2000                                   |                                                                                                                                                                                                          |                                                            | 3. Time of Death<br>2130                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4a. Facility Name (If not institution, give street and number)<br>2410 Cherokee Street |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    | 4b. City, Town, or Location of Death<br>Hyattsville                                  |                                                                                                                                                                                                          |                                                            | 4c. County of Death<br>Prince Georges        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br>577-18-6855                                               |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |                                                                                                                        | 7. Age (In yrs. last birthday)<br>80 Yrs.                                                                                                                                                        |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br>Apr. 8, 1920                                  |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Washington, DC |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Usual Residence of Decedent                                                            |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        | 10b. County<br>Prince Georges |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br>Adelphi                                                                                 |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                            |                                              |  |
| 10e. Street and Number<br>2410 Cherokee Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  | 10f. Zip Code<br>20783                                                                                                                             |                                                                                      | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |                                                            |                                              |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                    |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                            |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      | 16b. Kind of Business/Industry<br>Own Home                                                                                                                                                               |                                                            |                                              |  |
| 17. Father's Name (First, Middle, Last)<br>John J. Ronayne                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Agnes Gleason                                                                                 |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>William F. Dixon / Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>26070 Forest Hall Drive, Mechanicsville, MD 20659 |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery                                                                                                                                                                                                       |                                                                                                                        |                                                                                                                                                                                                  | Date<br>07/14/00                                                                                                                                   |                                                                                      | 20c. Location - City or Town, State<br>Silver Spring, Maryland                                                                                                                                           |                                                            |                                              |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  | 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904                      |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Atherosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                          |                                                            | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                            |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                            |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                            |                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                               | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                        | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                                                                                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          | 28d. Describe how injury occurred                          |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                                                                                                                                                                          |                                                            |                                              |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                        |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  | 29c. License number<br>H0055927                                                                                                                    |                                                                                      | 29d. Date signed (Month, Day, Year)<br>July 12, 2000                                                                                                                                                     |                                                            |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Salvador Sylvester 300 Hospital Drive, Chevy Chase, Maryland 20785                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                               | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                        |                                                                                                                                                                                                  |                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                          |                                                            |                                              |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 23456

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Eugene Patrick Dorney                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              | 2. Date of Death<br>Month Day Year<br>July 9, 2000                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                      |                                                          |                                                                  | 3. Time of Death<br>7:20 pm                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>3806 Delano Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              | 4b. City, Town, or Location of Death<br>Wheaton                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                          |                                                                  | 4c. County of Death<br>Montgomery                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>090-09-6500                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                        |                              | 7. Age (In yrs. last birthday)<br>85 Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>May 16, 1915      |                                                                  | 9. Birthplace (State or Foreign, Country)<br>New York New York                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         | 10b. County<br>Montgomery                                                                                                                             |                              | 10c. City, Town or Location<br>Wheaton                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      |                                                          |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br>3806 Delano Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              | 10f. Zip Code<br>20902                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      | 10g. Citizen of What Country?<br>USA                     |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                |                                                                                      |                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>US Customs Service Supervisor/ Inspector |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      | 16b. Kind of Business/Industry<br>Department of Treasury |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br>Patrick Eugene Dorney                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anne O'Connor                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Gertrude P. Dorney / Wife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3806 Delano Street, Wheaton, MD 20902                                                                                                                                                                                                                                                                                                                                          |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Gabriel's Cemetery                                                      |                              | Date<br>7/12/00                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      | 20c. Location - City or Town, State<br>Potomac, MD       |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc.<br>500 University Blvd., W, Silver Spring, MD 20901                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Aortic Stenosis years<br>Due to (or as a consequence of):<br>b. Calcific degenerative valve disease years<br>Due to (or as a consequence of):<br>c. Cardiopulmonary Failure months<br>Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Coronary Heart Disease<br>Carotid Artery Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                                       | 28b. Time of Injury<br>M     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                          | 28d. Describe how injury occurred                                |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                                       |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                          |                                                                  |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 29c. License number<br>25808 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                          | 29d. Date signed (Month, Day, Year)<br>7/10/00                   |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Herman Segal 10313 Georgia Ave Silver Spring Md 20902                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                          |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                                                       |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                          |                                                                  |                                                                                                    |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23457

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-638-2000.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>RODNEY DRIVER</b>                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. Date of Death<br>Month Day Year<br><b>JULY 5, 2000</b>                                                                                                                                       |  | 3. Time of Death<br><b>5:30 PM</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>17413 Redland Road</b>                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4b. City, Town, or Location of Death<br><b>Derwood</b>                                                                                                                                          |  | 4c. County of Death<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 5. Social Security Number<br><b>220-54-1022</b>                                                                                                                                                                                                                             |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                           |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.                                                                                                                                                |  | 8. Date of Birth (Month, Day, Year)<br><b>June 10, 1949</b>                                                                                                                                                                                                                                                                                                                                                                  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                 |  | 10e. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. County<br><b>Montgomery</b>                                                                                                                                                                |  | 10c. City, Town or Location<br><b>Derwood</b>                                                                                                                                                                                                                                                                                                                                                                                |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                              |  | 10e. Street and Number<br><b>17413 Redland Road</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 10f. Zip Code<br><b>20855</b>                                                                                                                                                                   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                               |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                              |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>1 yr</b>                                                                                                                                                               |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Capitol Project Manager</b>                                                                                                                                                                                                                                                                                          |  | 16b. Kind of Business/Industry<br><b>Montg. Co. Government</b>                                                                                                                                  |  | 17. Father's Name (First, Middle, Last)<br><b>Walter Driver</b>                                                                                                                                                                                                                                                                                                                                                              |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Meloise Jackson</b>                                                                                                                                                                                                 |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Georgia R. Driver (Wife)</b>                                                                                                                                                                                                                                                                                                                                                  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17413 Redland Road, Derwood, MD 20855</b>                                                   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cem.</b>                                                                                                                                                                        |  | 20c. Date<br><b>7/12/00</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20d. Location - City or Town, State<br><b>Silver Spring, MD</b>                                                                                                                                 |  | 21. Signature of Funeral Service Licensee<br><b>George R. Snowden</b>                                                                                                                                                                                                                                                                                                                                                        |  |
| 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>                                                                                                                                                                               |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardiopulmonary arrest</b><br>Due to (or as a consequence of):<br><b>Metastatic renal cell carcinoma</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death                                                                                                                                                    |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                             |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                       |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                              |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                               |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                               |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                 |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                             |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                           |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                 |  | 29c. License number<br><b>041373</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                                                                                                                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Baidas Said, M.D. 3800 Reservoir Rd., NW, Washington, DC 20016</b>                                                                                                                                                                                                                                                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                     |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 33. State Registrar                                                                                                                                                                             |  | 34. State Registrar                                                                                                                                                                                                                                                                                                                                                                                                          |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23458

Physician  
/Medical  
Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert L. Dulaney, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>July 5, 2000</b>                                                                                                                                                                                                                                   |  |                                                                                                                                                       |  | 3. Time of Death<br><b>2:18 pm</b>                                                             |  |                                                             |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                                                                                               |  |                                                                                                |  | 4c. County of Death<br><b>Montgomery</b>                    |  |
| 5. Social Security Number<br><b>578-10-2139</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                                                                                                                                                                            |  | If Under 1 Year<br>Months Days                                                                                                                        |  | If Under 24 Hrs.<br>Hours Min.                                                                 |  | 8. Date of Birth (Month, Day, Year)<br><b>April 3, 1920</b> |  |
| 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. County<br><b>Montgomery</b>                                                                                                                  |  | 10c. City, Town or Location<br><b>Kensington</b>                                                                                                                                                                                                                                            |  |                                                                                                                                                       |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                                             |  |
| 10e. Street and Number<br><b>#2 Orleans Terrace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>20895</b>                                                                                                                         |  | 10g. Citizen of What Country?<br><b>United States</b>                                          |  |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year of Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                               |  |                                                                                                                                                       |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>                                                                                                                                                              |  |                                                                                                                                                       |  | 16b. Kind of Business/Industry<br><b>N.O.A.A.</b>                                              |  |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert L. Delaney, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mamie Cox</b>                                                                                 |  |                                                                                                |  |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elaine R. Dulaney/ Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>#2 Orleans Terrace Kensington, Maryland 20895</b> |  |                                                                                                |  |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Columbia Gardens</b>                                                                                                                                                                                           |  | Date<br><b>July 10, 2000</b>                                                                                                                          |  | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>                              |  |                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>                                                                                                                                   |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardio Pulmonary Arrest</b><br><b>b. cardiomyopathy</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br><b>d.</b> |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Rheumatic Heart Disease</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                       |  | 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                 |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred                           |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  | 29c. License number<br><b>D54776</b>                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  | 29d. Date signed (Month, Day, Year)<br><b>July 6, 2000</b>                                     |  |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barton Leonard, MD 8600 Old Georgetown Rd,</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  | 32. Registrar's Signature<br>                                                                                                                                                                           |  |                                                                                                                                                       |  |                                                                                                |  |                                                             |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7/5/00  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

7/5/00  
14:18  
Robert Delaney

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23459

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Joseph DeFrank

2. Date of Death

Month  
JULY

Day

12,

Year

2000

3. Time of Death

4:15 A.M.

4a. Facility Name (If not institution, give street and number)

Berlin Nursing and Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

187-18-0952

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
May 22, 1915

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Ocean Pines

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Mist Flower Rd.

10f. Zip Code

21811

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Chemist Metalurgist

16b. Kind of Business/Industry

Coating Engineering

17. Father's Name (First, Middle, Last)

Anthony DeFrank

18. Mother's Name (First, Middle, Maiden Surname)

Antoinette McAloose

19a. Informant's Name/Relationship (Type, Print)

Mary A. Coleman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Mist Flower Rd., Ocean Pines, Md. 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rosemont Cemetery

Date

7-15-00

20c. Location - City or Town, State

Bloomsburg, Pa.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home  
108 William St., Berlin, Md. 2181123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or renal failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Alzheimer's Disease Terminal  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

year.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. C  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

July 12 - 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FEDERICO ARTHES, M.D. 46 TEAL CIRCLE, BERLIN, MD 21811 410-641-4400

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

State  
RegistrarDEFRANK, PHILLIP  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23460

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Susie R. Donaldson

2. Date of Death

Month Day Year  
July 8 2000

3. Time of Death

2:12 AM

4a. Facility Name (If not institution, give street and number)

Millenium Health &amp; Rehab. Ctr.

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216-32-0529

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 16, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

144 Washington Road

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

State Archivist Office

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

William Raleigh Suitt

18. Mother's Name (First, Middle, Maiden Surname)

Susie Virginia Bullen

19a. Informant's Name/Relationship (Type, Print)

Joan Spelts / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9114 Alexandria Dr. Weeki Wachee, FL. 34613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mayo U.M. Cemetery

Date

7-10-00

20c. Location - City or Town, State

Mayo, MD.

21. Signature of Funeral Service Licensee

C.B. Powell

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.  
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gyan Chandra

29c. License number

D50653

29d. Date signed (Month, Day, Year)

7/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gyan C. Surana, M.D.

5851 Deale Churchton Rd. Suite 16 Deale, MD 20751

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 11 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 19b AACO Health CMH

State of Maryland / Department of Health and Mental Hygiene

00 23461

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br><b>Carrie May Diehl</b>                             |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 10, 2000</b> |                                                                                                                                                                                                  |                                                            |                                                                                                | 3. Time of Death<br><b>6:00 am</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br><b>Future Care Chesapeake</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Arnold</b>      |                                                                                                                                                                                                  |                                                            |                                                                                                | 4c. County of Death<br><b>Anne Arundel</b>                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br><b>221-03-1122</b>                                                 |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.           |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>May 12, 1914</b> |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                                     |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                          |                                                                            | 10c. City, Town or Location<br><b>Arnold</b>                                                                                                                                                 |                                                            |                                                                                                                                                                                                  |                                                            | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                             |  |
| 10e. Street and Number<br><b>709 Cottage Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            | 10f. Zip Code<br><b>21012</b>                                                                                                                                                                |                                                            |                                                                                                                                                                                                  |                                                            | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                            |                                                                                                                                                                                                  |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                |                                                            |                                                                                                                                                                                                  |                                                            | 16b. Kind of Business/Industry<br><b>Home</b>                                                  |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Carroll Scott Barr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Irma Baker</b>                                                                                                                         |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dr. Kenneth W. Diehl/ son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7518 Knollwood Road, Baltimore, MD <del>21280</del> 21286</b>                            |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parsons Cemetery</b>                                                                                                                                                                                           |                                                                            | 20c. Date<br><b>July 14 2000</b>                                                                                                                                                             |                                                            | 20d. Location - City or Town, State<br><b>Salisbury, MD</b>                                                                                                                                      |                                                            |                                                                                                |                                                             |  |
| 21. Signature of Funeral Service Director<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>                                             |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>hypertension</b><br>Due to (or as a consequence of):<br>c. <b>diabetes</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>years</b><br><b>years</b> |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>dementia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                            |                                                                                                |                                                             |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                            |                                                                                                |                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                            | 28d. Describe how injury occurred                                                              |                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                      |                                                                                                 | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>041955</b>                                                                                                                                                         |                                                            | 29d. Date signed (Month, Day, Year)<br><b>7-10-00</b>                                                                                                                                            |                                                            |                                                                                                |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rebecca Elton MD 479 Jumpers Hole Rd #304 Severna Park MD 21146</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                              |                                                            |                                                                                                                                                                                                  |                                                            |                                                                                                |                                                             |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 23462

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><u>Sucio Duncan</u>                             |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <u>7</u> Day <u>4</u> Year <u>2000</u> |                                                                                                                                                                                              | 3. Time of Death<br><u>1:35 A</u>                                                           |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><u>8200 KILMORY COURT</u> |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><u>SEVERN</u>            |                                                                                                                                                                                              | 4c. County of Death<br><u>ANNE ARUNDEL</u>                                                  |                                                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><u>254-54-3873</u>                                             |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><u>63</u> Yrs.                 |                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><u>MARCH 9 1937</u>                                  |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br><u>GEORGIA</u>                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
| 10a. State<br><u>MARYLAND</u>                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |  | 10b. County<br><u>ANNE ARUNDEL</u>                                                                                                                                                                                                                                                          |  |                                                                  | 10c. City, Town or Location<br><u>SEVERN</u>                                                                                                                                                 |                                                                                             |                                                      |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |  | 10e. Street and Number<br><u>8200 KILMORY COURT</u>                                                                                                                                                                                                                                         |  |                                                                  | 10f. Zip Code<br><u>21144</u>                                                                                                                                                                |                                                                                             | 10g. Citizen of What Country?<br><u>USA</u>          |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                     |                                                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  |                                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             |                                                      |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>9th</u> College (1-4 or 5+) <u>0</u>                                                                                                                                                      |  |                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>HEAVY EQUIPMENT OPERATOR HALLE &amp; COMPANY</u>                             |                                                                                             |                                                      |  |
| 16b. Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |  | 17. Father's Name (First, Middle, Last)<br><u>SUCIC DUNCAN</u>                                                                                                                                                                                                                              |  |                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>LUCY MAE YOUNG</u>                                                                                                                   |                                                                                             |                                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>CATHERINE DUNCAN (WIFE)</u>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>8200 KILMORY COURT SEVERN, MD. 21144</u>                                                                                                                                                |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                              |                                                                                             |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>ANNAPOLIS MEM. GARDENS</u>                                                                                                                                                                                     |  |                                                                  | 20c. Location - City or Town, State<br><u>7/7/00 ANNAPOLIS, MD.</u>                                                                                                                          |                                                                                             |                                                      |  |
| 21. Signature of Funeral Service Licensee<br><u>Harry D. Reese MD0482</u>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |  | 22. Name and Address of Facility<br><u>WM. REESE &amp; SONS MORTUARY, P.A.</u><br><u>821 WEST ST. ANNAPOLIS, MD. 21401</u>                                                                                                                                                                  |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                             |  | a. <u>Pneumonia</u><br>Due to (or as a consequence of):                                                                                                                                                                                                                                     |  |                                                                  | Approximate Interval Between Onset and Death<br><u>1 week</u>                                                                                                                                |                                                                                             |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |  | b. <u>Lung Cancer</u><br>Due to (or as a consequence of):                                                                                                                                                                                                                                   |  |                                                                  | <u>16 months</u>                                                                                                                                                                             |                                                                                             |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |  | c. _____<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |  | d. _____<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes</u>                                                                                                                                                                                                                                                                                                          |                                                                                             |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |  |                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                           |                                                                                             |                                                      |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                                                             |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                         |                                                                                             |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br><u>M</u>                                  |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |  |                                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                       |                                                                                             |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |                                                                                             |  | 29b. Signature and title of certifier<br><u>R. Austin Doyle MD</u>                                                                                                                                                                                                                          |  |                                                                  | 29c. License number<br><u>D23809</u>                                                                                                                                                         |                                                                                             | 29d. Date signed (Month, Day, Year)<br><u>7/6/00</u> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>L. Austin Doyle, M.D., Greenbaum Cancer Ctr, 22 South Greene St., Baltimore, MD 21201</u>                                                                                                                                                                                                                                                               |                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 10 2000</u>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             |  | 32. Registrar's Signature<br><u>B. Sparks</u>                                                                                                                                                                                                                                               |  |                                                                  |                                                                                                                                                                                              |                                                                                             |                                                      |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23463

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------|----|---------------|----------------------------------------------|----------------------------------|--|----------------|----|----------------------|----------------|----------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----|--|--|----|--|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>VIOLA DAY</b>                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            | 2. Date of Death<br>Month Day Year<br><b>JULY 01 2000</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>2015</b>                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                                                                                                                                                                                  | 4c. County of Death<br><b>NONE</b>                          |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>212-54-7504</b>                                                  |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.                                                                                                                                             |                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 9 1934</b> |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  | 10b. County<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                                          |                                                                                                                                                   | 10c. City, Town or Location<br><b>GLEN BURNIE</b>                                                                            |                                                                                                                                                                                              |                                                                                                                                            |                                                           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 10e. Street and Number<br><b>102 CRAIN HIGHWAY N. APT. 923</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 10f. Zip Code<br><b>21061</b>                                                                                                |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                            |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                          |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC</b> |                                                                                                                                                                                              |                                                                                                                                            | 16b. Kind of Business/Industry<br><b>OUT OF THE HOME</b>  |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>BENJAMIN DAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LOUISE DAY</b>                                                                     |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DORINE WHITE (DAUGHTER)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>968 STOLL ST. BALTIMORE, MD. 21225</b> |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ANNAPOLIS MEM. GARDENS</b>                                           |                                                                                                                              |                                                                                                                                                                                              | 20c. Location - City or Town, State<br><b>7/6/00 ANNAPOLIS, MD.</b>                                                                        |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Harry J. Reese M00482</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>                       |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>SEPSIS</b></td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td><b>37 DAYS</b></td> </tr> <tr> <td>b.</td> <td><b>MEDIASTINITIS</b></td> <td><b>37 DAYS</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             | Immediate Cause (Final disease or condition resulting in death) | a. | <b>SEPSIS</b> | Approximate Interval Between Onset and Death | Due to (or as a consequence of): |  | <b>37 DAYS</b> | b. | <b>MEDIASTINITIS</b> | <b>37 DAYS</b> | Due to (or as a consequence of): |  |  | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. |  |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | a.                                                                                               | <b>SEPSIS</b>                                                                                                                                                                                                                                                                               | Approximate Interval Between Onset and Death                                                                                                      |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Due to (or as a consequence of):                                                                 |                                                                                                                                                                                                                                                                                             | <b>37 DAYS</b>                                                                                                                                    |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | b.                                                                                               | <b>MEDIASTINITIS</b>                                                                                                                                                                                                                                                                        | <b>37 DAYS</b>                                                                                                                                    |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Due to (or as a consequence of):                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | c.                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | d.                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br>M                                                                                                     |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                |                                                           | 28d. Describe how injury occurred                                                                                                                                                                |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                               |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                              |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 29b. Signature and title of certifier<br><b>Krishna M. Sharma MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              | 29c. License number<br><b>AT2438946-A19</b>                                                                                                |                                                           | 29d. Date signed (Month, Day, Year)<br><b>JULY 01 2000</b>                                                                                                                                       |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KRISHNA M. SHARMA DEPT. OF SURGERY 201 E. UNIVERSITY PKWY BALTIMORE MD 21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  | 32. Registrar's Signature<br><b>B. Spach</b>                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                            |                                                           |                                                                                                                                                                                                  |                                                             |                                                                 |    |               |                                              |                                  |  |                |    |                      |                |                                  |  |  |                                                                                                                                                          |    |  |  |    |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23464

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 |                                                                                                                                                                                  |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br><b>Ernest A. Donaldson</b>                                       |                                                                                                        |                                 |                                                                                                                                                                                  | 2. Date of Death<br>Month <b>July</b> Day <b>3</b> Year <b>2000</b> |                                                       |                                                            |                                                                              | 3. Time of Death<br><b>12:30 AM</b>                           |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br><b>Millenium Health and Rehabilitation</b> |                                                                                                        |                                 |                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>Edgewater</b>            |                                                       |                                                            |                                                                              | 4c. County of Death<br><b>Anne Arundel</b>                    |                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br><b>214-05-0173</b>                                                              |                                                                                                        | 6. Sex<br><b>1</b> M <b>2</b> F |                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.                    |                                                       | 8. Date of Birth (Month, Day, Year)<br><b>May 20, 1907</b> |                                                                              | 9. Birthplace (State or Foreign Country)<br><b>Wash. D.C.</b> |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                | Usual Residence of Decedent                                                                                  |                                                                                                        |                                 |                                                                                                                                                                                  |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                              | 10b. County<br><b>Anne Arundel</b>                                                                     |                                 | 10c. City, Town or Location<br><b>Edgewater</b>                                                                                                                                  |                                                                     |                                                       |                                                            | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                          |                                                               |                                   |  |
| 10e. Street and Number<br><b>144 Washington Road</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                              |                                                                                                        |                                 | 10f. Zip Code<br><b>21037</b>                                                                                                                                                    |                                                                     | 10g. Citizen of What Country?<br><b>United States</b> |                                                            |                                                                              |                                                               |                                   |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                                                                                                                                                                                                                                                            |                                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:                                |                                                                     |                                                       |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>      |                                                               |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                        |                                                                                                              |                                                                                                        |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Engineer</b>                                        |                                                                     |                                                       |                                                            | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                     |                                                               |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Wilbur Donaldson</b>                                                                                                                                                                                                                                                                                                             |                                                                                                              |                                                                                                        |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Mayhew</b>                                                                                                          |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Spelts/daughter</b>                                                                                                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9114 Alexandria Dr. Weeki Wachee, FL 34613</b>                               |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                                                                                                                                                                                                                                     |                                                                                                              |                                                                                                        |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mayo U.M. Church Cem.</b>                                                                           |                                                                     | 20c. Date<br><b>7/6/00</b>                            |                                                            | 20d. Location - City or Town, State<br><b>Mayo, MD</b>                       |                                                               |                                   |  |
| 21. Signature of Funeral Service Licensee<br><b>Todd Miller</b>                                                                                                                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home</b><br><b>147 Duke of Gloucester St. Annapolis MD</b>                                                         |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                      |                                                                                                              |                                                                                                        |                                 |                                                                                                                                                                                  |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 | a. <b>ACUTE PULMONARY EDEMA</b><br>Due to (or as a consequence of):                                                                                                              |                                                                     |                                                       |                                                            | Approximate Interval Between Onset and Death<br><b>Approx. 8 HRS.</b>        |                                                               |                                   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                        |                                                                                                              |                                                                                                        |                                 | b. <b>ATHEROSCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):                                                                                                      |                                                                     |                                                       |                                                            | MORE THAN<br><b>1 YEAR</b>                                                   |                                                               |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 | c. _____<br>Due to (or as a consequence of):                                                                                                                                     |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 | d. _____<br>Due to (or as a consequence of):                                                                                                                                     |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 |                                                                                                                                                                                  |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>                                                                                                                                                                                                                                      |                                                                                                              |                                                                                                        |                                 |                                                                                                                                                                                  |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                                                                                                                                                                                                                                                          |                                                                                                              |                                                                                                        |                                 |                                                                                                                                                                                  |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                     |                                                                                                              |                                                                                                        |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                                                                          |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                         |                                                                                                              |                                                                                                        |                                 | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify) |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide                                                                                                                                                                                                             |                                                                                                              |                                                                                                        |                                 | 28a. Date of Injury (Month, Day Year)                                                                                                                                            |                                                                     | 28b. Time of Injury<br><b>M</b>                       |                                                            | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                             |                                                               | 28d. Describe how injury occurred |  |
|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                           |                                                                     |                                                       |                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                               |                                   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                              |                                                                                                        |                                 |                                                                                                                                                                                  |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 29b. Signature and title of certifier<br><b>Taylor</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                              |                                                                                                        |                                 | 29c. License number<br><b>D 50653</b>                                                                                                                                            |                                                                     |                                                       |                                                            | 29d. Date signed (Month, Day, Year)<br><b>7-3-2000</b>                       |                                                               |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GYAN-C. SURANA MD</b><br><b>5851 Deale Church Rd. Deale MD 20751</b>                                                                                                                                                                                                                |                                                                                                              |                                                                                                        |                                 |                                                                                                                                                                                  |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                              |                                                                                                        |                                 | 32. Registrar's Signature<br><b>P. Sparks</b>                                                                                                                                    |                                                                     |                                                       |                                                            |                                                                              |                                                               |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NOT A 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23465

## Certificate of Death

Reg. No.

|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                        |  |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Edith Ursula DOWNEY                                                                                                                                                                                                                                                                                                                                                               |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2. Date of Death<br>Month Day Year<br>July 2, 2000                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 3. Time of Death<br>0830                                                                                                                                                                                                                                                               |  |
|                                                  | 4a. Facility Name (If not Institution, give street and number)<br>11211 Kemps Mill Road                                                                                                                                                                                                                                                                                                                                       |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4b. City, Town, or Location of Death<br>Williamsport                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 4c. County of Death<br>Washington                                                                                                                                                                                                                                                      |  |
| Funeral<br>Director                              | 5. Social Security Number<br>212-38-8443                                                                                                                                                                                                                                                                                                                                                                                      |                                        | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br>84 Yrs.                                                                             |  | If Under 1 Year<br>Months Days                                                                                                                                                                                                                                                                          |  | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                                                                                                         |  |
|                                                  | 8. Date of Birth<br>(Month, Day, Year)<br>Oct. 30, 1915                                                                                                                                                                                                                                                                                                                                                                       |                                        | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10a. State<br>Maryland                                                                                                |  | 10b. County<br>Washington                                                                                                                                                                                                                                                                               |  | 10c. City, Town or Location<br>Williamsport                                                                                                                                                                                                                                            |  |
| To Be Completed by Funeral Director              | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                        | 10e. Street and Number<br>11211 Kemps Mill Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10f. Zip Code<br>21795                                                                                                |  | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                                                                                                                                                                 |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                 |  |
|                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                         |                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                                      |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-12<br>College (1-4 or 5+) 4                                                                                                                                                                            |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>home economics teacher                                                                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner    | 16b. Kind of Business/Industry<br>schools                                                                                                                                                                                                                                                                                                                                                                                     |                                        | 17. Father's Name (First, Middle, Last)<br>Keller Byers Bell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Amy Cordelia Leshner                                             |  | 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Richmond Lee Downey / son                                                                                                                                                                                                                       |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11211 Kemps Mill Road, Williamsport, Maryland 21795                                                                                                                                   |  |
|                                                  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Paul's Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Date<br>July 6, 2000                                                                                                  |  | 20c. Location - City or Town, State<br>Clear Spring, Maryland                                                                                                                                                                                                                                           |  | 21. Signature of Funeral Service Licensee<br>Fred L. Lister                                                                                                                                                                                                                            |  |
| Physician<br>/Medical<br>Examiner                | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740                                                                                                                                                                                                                                                                                                                 |                                        | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>RENAL FAILURE, CHRONIC</u><br>Due to (or as a consequence of):<br>b. <u>SCLERODERMA</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>1 year<br>Years                                                       |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>PULMONARY EMBOLI</u><br><u>ARTERIO SCLEROTIC HEART DISEASE</u>                                                                                                             |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                          |  |
|                                                  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                        | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
| State Registrar                                  | 28a. Date of Injury (Month, Day, Year)<br>None                                                                                                                                                                                                                                                                                                                                                                                |                                        | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                  |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                           |  |
|                                                  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                        | 29b. Signature and title of certifier<br>B. A. ...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 29c. License number<br>D01040                                                                                         |  | 29d. Date signed (Month, Day, Year)<br>07-03-00                                                                                                                                                                                                                                                         |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>BANK M. COMPTON, M.D., 18706 CRESTWOOD DRIVE, HAGERSTOWN, MD, 21742                                                                                                                            |  |
| 31. Date filed (Month, Day, Year)<br>JUL 03 2000 |                                                                                                                                                                                                                                                                                                                                                                                                                               | 32. Registrar's Signature<br>B. A. ... |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                        |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23466

NAME KNOWN TO PHYSICIAN: DELVECCHIO, RAYMOND

Baltimore, Maryland 21215-0020

\* Cause of death ok'd by Diana Boyer, MD

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br>Raymond A. DelVecchio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 2. Date of Death<br>Month Day Year<br>JUNE 17, 2000                                                                                                                                          |                                                      |                                                                                      | 3. Time of Death<br>8:10 AM                                                                    |                                   |  |
| 4a. Facility Name (If not institution, give street and number)<br>VA MARYLAND HEALTH CARE SYSTEM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 4b. City, Town, or Location of Death<br>PERRY POINT                                                                                                                                          |                                                      |                                                                                      | 4c. County of Death<br>CECIL                                                                   |                                   |  |
| 5. Social Security Number<br>577-24-8589                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                     | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                  |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>78 Yrs. |                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br>June 14, 1922 |                                                                                      | 9. Birthplace (State or Foreign Country)<br>Wash, D.C.                                         |                                   |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 10a. State<br>none                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. County<br>none |                                                                                                                                                             | 10c. City, Town or Location<br>Washington, D.C.                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |
| 10e. Street and Number<br>3535 New Hampshire Ave., N.W.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 10f. Zip Code<br>20011                                                                                                                                                                       |                                                      |                                                                                      | 10g. Citizen of What Country?<br>USA                                                           |                                   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: 1942-1944 |                                                                                                                                                                                                                                                                                                         |                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                      |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Soldier                                                                         |                                                      |                                                                                      | 16b. Kind of Business/Industry<br>U.S. Army                                                    |                                   |  |
| 17. Father's Name (First, Middle, Last)<br>Guierino DelVecchio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>Addoloratta DeSantis                                                                                                                    |                                                      |                                                                                      |                                                                                                |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Edward T. Love/Conservator                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4816 Moorland Lane Bethesda, MD 20814                                                       |                                                      |                                                                                      |                                                                                                |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                     |                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery                                                                                                                                                                                                          |                                           |                                                                                                                                                                                              |                                                      | 20c. Location - City or Town, State<br>Brentwood, Maryland                           |                                                                                                | 20d. Date<br>June 27, 2000        |  |
| 21. Signature of Funeral Service Licensee<br><i>John F. DelVecchio</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 22. Name and Address of Facility<br>DeVol Funeral Home<br>2222 Wisconsin Ave., N.W.<br>Washington, D.C. 20007                                                                                |                                                      |                                                                                      |                                                                                                |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>CARDIAC ARREST SECONDARY TO ACUTE ISCHEMIC EVENT</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>HYPOTHYROIDISM</u><br><u>SCHIZOAFFECTIVE DISORDER, BIPOLAR</u><br><u>BENIGN PROSTATIC HYPERTROPHY</u>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                     |                                                                                                                                                             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                          |  |                     |                                                                                                                                                             | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                           | 28b. Time of Injury<br>M                                                                                                                                                                     |                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                     |                                                                                                                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                             |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 29b. Signature and title of certifier<br><i>O. Odelowo M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 29c. License number<br>01049148                                                                                                                                                              |                                                      |                                                                                      | 29d. Date signed (Month, Day, Year)<br>JUNE 17, 2000                                           |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>OLAJIDE ODELOWO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                              |                                                      |                                                                                      |                                                                                                |                                   |  |
| 31. Date filed (Month, Day, Year)<br>JUN 27 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                           | 32. Registrar's Signature<br><i>Benita S. Sparks</i>                                                                                                                                         |                                                      |                                                                                      |                                                                                                |                                   |  |

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23467

Amended Item#17 per FHG785 7/25/2000 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lenora Mamie Duppins

2. Date of Death

June 26, 2000

3. Time of Death

8:08 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

220-16-1578

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 10, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick10c. City, Town or Location  
Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1421 Taney Ave.

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Alice L. Duppins

19a. Informant's Name/Relationship (Type, Print)

Elaine N. Sands / niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20619 Shadyside Way, Germantown, Maryland 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
Resthaven Memorial Gardens

Date

06-30-00

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home  
1621 Opossumtown Pike/ Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Heart Disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 16428

29d. Date signed (Month, Day, Year)

6/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline, III, 300 West Ninth St./ Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23468

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Pauline Frances Eagle                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                                                       |                               | 2. Date of Death<br>Month: July Day: 7 Year: 2000                                                                                                                                                 |                                                                                      |                                                      |                                                                  | 3. Time of Death<br>5:44PM                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Glade Valley Nursing Center                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                                                       |                               | 4b. City, Town, or Location of Death<br>Walkersville                                                                                                                                              |                                                                                      |                                                      |                                                                  | 4c. County of Death<br>Frederick                                                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>219-20-3340                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                               | 7. Age (In yrs. last birthday)<br>93 Yrs.                                                                                                                                                         |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Feb. 21, 1907 |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        | 10b. County<br>Frederick                                                                                                                              |                               | 10c. City, Town or Location<br>Woodsboro                                                                                                                                                          |                                                                                      |                                                      |                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>102 S. Second St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                                                       |                               | 10f. Zip Code<br>21798                                                                                                                                                                            |                                                                                      | 10g. Citizen of What Country?<br>U.S.A.              |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                            |                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+) 5                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        |                                                                                                                                                       |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>general duties                                                                       |                                                                                      |                                                      | 16b. Kind of Business/Industry<br>perfume company                |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Frank Tilden Crum                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                                                       |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Pansy Irene Fox                                                                                                                              |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Charles H. Crum - nephew                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                                                       |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>302 S. Second St., Woodsboro, MD 21798                                                           |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                   |                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Hope Cemetery                                                           |                               | Date<br>July 11 2000                                                                                                                                                                              |                                                                                      | 20c. Location - City or Town, State<br>Woodsboro, MD |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Jondie L. Brothers                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               | 22. Name and Address of Facility<br>Hartzler Funeral Home<br>404 S. Main St., Woodsboro, MD                                                                                                       |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Systemic lupus erythematosus<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>2 yrs |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28a. Date of Injury (Month, Day Year)                                                  |                                                                                                                                                       | 28b. Time of Injury<br>M      |                                                                                                                                                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how injury occurred                                |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                                                                                                                                                       |                               |                                                                                                                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                      |                                                                  |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| 29b. Signature and title of certifier<br>Gene F. Ashe, M.D.                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       | 29c. License number<br>D31058 |                                                                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br>7-10-00                                       |                                                      |                                                                  |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gene F. Ashe, M.D. 10200 Coppermine Road, Woodsboro, MD 21798                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 32. Registrar's Signature<br>Beverly B. Sparks                                         |                                                                                                                                                       |                               |                                                                                                                                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 28c per phys. G786 8/28/00 yf

Certificate of Death

Reg. No.

00 23469

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET ELIZABETH ENGLISH</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. Date of Death<br>Month Day Year<br><b>JULY 2, 2000</b>                                                                                                                                                                                                                                   |                                                                                                                                                           | 3. Time of Death<br><b>2:00 AM</b>                                                                                                                                                            |                                                                                                                                                                                                  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>                                                                                                                                                                                                                                     |                                                                                                                                                           | 4c. County of Death<br><b>Prince George's</b>                                                                                                                                                 |                                                                                                                                                                                                  |
| 5. Social Security Number<br><b>230-01-9723</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                                                                                                                                              |                                                                                                                                                                                                  |
| 8. Data of Birth (Month, Day, Year)<br><b>Oct. 24, 1920</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                 |                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. County<br><b>Prince George's</b>                                                                                                                                                                                                                                                       |                                                                                                                                                           | 10c. City, Town or Location<br><b>Temple Hills</b>                                                                                                                                            |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>6300 Middleton Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10f. Zip Code<br><b>20748</b>                                                                                                                                                                                                                                                               |                                                                                                                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                     |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>Collage (1-4or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                             |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                                                                                                               |                                                                                                                                                           | 16b. Kind of Business/Industry<br><b>Own Home</b>                                                                                                                                             |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>William Henry Butler</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Betty Rose Reid</b>                                                                               |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Selma E. Doctrow/Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2662 Husk Place, Apt.202, Waldorf, Maryland 20602</b> |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                              |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery 07-07-2000</b>                                                                                                                                                                            |                                                                                                                                                           | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>                                                                                                                             |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br><b>MARK G. BROHAWN MO0053</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br><b>The Hunt Funeral Home, Inc.<br/>P.O. Box 156, Waldorf, Maryland 20604</b>                                                                                                                                                                            |                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>immediata Causa (Final disease or condition resulting in death)<br><b>a. Carcinoma of Pancreas</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                                                                                                                                                                                               | Approximate Interval Between Onset and Death                                                                                                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Intestinal obstruction</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                                                                                                                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                                                                                                                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicida <input type="checkbox"/> Homicida                                                                                                                                                                                                      |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                           | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |                                                                                                                                                           | 28d. Describe how injury occurred                                                                                                                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                          |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br><b>MD Attending</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 29c. License number<br><b>D18104</b>                                                                                                                                                                                                                                                        |                                                                                                                                                           | 29d. Date signed (Month, Day, Year)<br><b>7/3/2000</b>                                                                                                                                        |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>T SURY MD 6005 LANDOVER ROAD #6 CHEVERLY MD 20785</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                               |                                                                                                                                                           |                                                                                                                                                                                               |                                                                                                                                                                                                  |

State Registrar





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State of Maryland / Department of Health and Mental Hygiene

00 23470

## Certificate of Death

Reg. No.

|                                                                                                                                                                      |                                                                                                                                                                                                                                                 |  |                                                                                |                                                                              |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Louise E. Eaton</b>                                                                                                                                                                              |  |                                                                                |                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 11, 2000</b>                                                                                                                                                                                                                                              |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 3. Time of Death<br><b>7:55 pm</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
|                                                                                                                                                                      | 4a. Facility Name (If not Institution, give street and number)<br><b>Holy Cross Hospital</b>                                                                                                                                                    |  |                                                                                |                                                                              | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>                                                                                                                                                                                                                                            |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4c. County of Death<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
| Funeral<br>Director                                                                                                                                                  | 5. Social Security Number<br><b>579-18-1055</b>                                                                                                                                                                                                 |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                              | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                                                                                                                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br><b>Apr 18, 1922</b>                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
|                                                                                                                                                                      | Usual Residence of Decedent                                                                                                                                                                                                                     |  |                                                                                |                                                                              | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                           |  | 10b. County<br><b>Montgomery</b>                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10c. City, Town or Location<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| To Be Completed by Funeral Director                                                                                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                              |  |                                                                                |                                                                              | 10e. Street and Number<br><b>321 University Blvd., West Apt 139</b>                                                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10f. Zip Code<br><b>20901</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
|                                                                                                                                                                      | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                     |  |                                                                                |                                                                              | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                  |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                            |  |
|                                                                                                                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                               |  |                                                                                |                                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                 |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
|                                                                                                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retail Clothing Sales</b>                                                                                                       |  |                                                                                |                                                                              | 16b. Kind of Business/Industry<br><b>Retail</b>                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br><b>Raymond Lee Dawes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
|                                                                                                                                                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lottie Lee Snead</b>                                                                                                                                                                    |  |                                                                                |                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>Janet L. Moser / Daughter</b>                                                                                                                                                                                                                    |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1619 Dublin Drive, Silver Spring, MD 20902</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |
|                                                                                                                                                                      | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |                                                                                |                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>                                                                                                                                                                                                  |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20c. Location - City or Town, State<br><b>7/15/00 Brentwood, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
|                                                                                                                                                                      | 21. Signature of Funeral Service Licensee<br>                                                                                                                 |  |                                                                                |                                                                              | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W, Silver Spring, MD 20901</b>                                                                                                                                                                   |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Hemorrhagic Shock</b><br>Due to (or as a consequence of):<br><br>b. <b>Gastrointestinal Hemorrhage</b><br>Due to (or as a consequence of):<br><br>c. <b>Severe Anemia</b><br>Due to (or as a consequence of):<br><br>d. <b>Renal Insufficiency</b> |  |
|                                                                                                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                        |  |                                                                                |                                                                              | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                               |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                           |  |
|                                                                                                                                                                      | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                           |  |                                                                                |                                                                              | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                              |  |
|                                                                                                                                                                      | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                           |  |                                                                                |                                                                              | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                               |                                                                                                                                                                                                                                                 |  |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                                                                                                                         |  |                                                                                      | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                         |                                                                                                                                                                                                                                                 |  |                                                                                | 29c. License number<br><b>D 41624</b>                                        |                                                                                                                                                                                                                                                                                                         |  |                                                                                      | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>G. Patrick Murphy, MD 1500 Forest Glenn Road, Silver Spring, MD 20910</b> |                                                                                                                                                                                                                                                 |  |                                                                                | 31. Date filed (Month, Day, Year)<br><b>JUL 13 2000</b>                      |                                                                                                                                                                                                                                                                                                         |  |                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23471

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Ghulam Faraz</b>                              |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>July</b> Day <b>8</b> Year <b>2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>12:40A.</b>               |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Lorien Nursing Home</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Columbia</b>             |                                                                                                                                                                                              | 4c. County of Death<br><b>Howard</b>             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>219-92-2898</b>                                              | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.                    | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>                                                                                                                                             | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>May 29, 1918</b>                                   |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Puna, India</b>      |                                                                                                                                                                                              |                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              | 10b. County<br><b>Montgomery</b>                                                                                                                                                                                                                                                            |                                                                     | 10c. City, Town or Location<br><b>Gaithersburg</b>                                                                                                                                           |                                                  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| 10e. Street and Number<br><b>11 Norwich Court</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              | 10f. Zip Code<br><b>20878</b>                                                                                                                                                                                                                                                               |                                                                     | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                        |                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                        |                                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Banker</b>                                                                                                                                                                  |                                                                     | 16b. Kind of Business/Industry<br><b>Grindlays Bank</b>                                                                                                                                      |                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>Essa Khan</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marzieh Mehelati</b>                                                                                                                                                                                                                |                                                                     |                                                                                                                                                                                              |                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sarwar Faraz(son)</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20808 Scottsbury Drive Germantown, Maryland 20876</b>                                                                                                                                   |                                                                     |                                                                                                                                                                                              |                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland National Mem. Park 7/8/2000 Laurel, Maryland</b>                                                                                                                                                      |                                                                     | 20c. Location - City or Town, State                                                                                                                                                          |                                                  |
| 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                              | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>                                                                                                                                                       |                                                                     |                                                                                                                                                                                              |                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | a. <b>renal failure</b>                                                                                                                                                                                                                                                                     |                                                                     | Due to (or as a consequence of):                                                                                                                                                             |                                                  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                   |                                                                                              | b. <b>hypertension</b>                                                                                                                                                                                                                                                                      |                                                                     | Due to (or as a consequence of):                                                                                                                                                             |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | c.                                                                                                                                                                                                                                                                                          |                                                                     | Due to (or as a consequence of):                                                                                                                                                             |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | d.                                                                                                                                                                                                                                                                                          |                                                                     | Due to (or as a consequence of):                                                                                                                                                             |                                                  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                  |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                           |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>vegetative state</b>                                                                                                                                                                                                                                                                            |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                     |                                                                                                                                                                                              |                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |                                                                                              | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                     | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |                                                                     | 28d. Describe how injury occurred                                                                                                                                                            |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| 29b. Signature and title of certifier<br><b>Gary Kaelow MD</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                                              | 29c. License number<br><b>DY1617</b>                                                                                                                                                                                                                                                        |                                                                     | 29d. Date signed (Month, Day, Year)<br><b>July 8, 2000</b>                                                                                                                                   |                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gary Kaelow MD 10805 Hickory Ridge Rd Columbia Md 21044</b>                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              | 32. Registrar's Signature<br><b>Anna B. Sparks</b>                                                                                                                                                                                                                                          |                                                                     |                                                                                                                                                                                              |                                                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-692-2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #23a;Pt-I, 7/14/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

00 23472

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert E. Felix

2. Date of Death

Month Day Year  
July 10, 2000

3. Time of Death

10:40 pm

4a. Facility Name (If not institution, give street and number)

1728 Biggs Highway

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

183-12-9629

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 26, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Selbyville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

RR 1 Box 131

10f. Zip Code

19975

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Bureau of Engraving

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Lois Chapman / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RR 1 Box 131, Selbyville, DE 19975

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7/14/00

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

James S. Ooley

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Congestive Heart Failure

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure  
Myocardial Infarction  
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural 5 ☐ Pending investigation  
☐ Accident 6 ☐ Could not be determined  
☐ Suicide  
☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas Biondo MD

29c. License number

D42800

29d. Date signed (Month, Day, Year)

7/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Biondo, MD 319 South Union Ave., Harve DeGrace, MD 21078

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23473

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn L. Fishback

2. Date of Death

Month Day Year  
July 10 2000

3. Time of Death

3:00 P. M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

056-03-9072

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
May 3, 1907

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

7817 Moorland Lane

10f. Zip Code

20814

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Walter Klein

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Roe

19a. Informant's Name/Relationship (Type, Print)

James F. Fishback - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3004 Dartmouth Road Alexandria, VA 22314

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

National Crematory

Date

7/15/00

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

Thomas E. Hornbaker

22. Name and Address of Facility

Joseph Gawler's Sons

5130 WI Ave. N.W. Washington, D. C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Colon Cancer

Approximate Interval Between Onset and Death

MONTHS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gabriel A. Berrebi MD

29c. License number

B30692

29d. Date signed (Month, Day, Year)

July 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gabriel A. Berrebi, M. D. 15225 Shady Grove Road Rockville, MD 20850

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Fishback, Evelyn 7-10-00 1500





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23474

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br><b>Suzanne Fleran</b>                              |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>July 5, 2000</b> |                                                                                                 |                                                             |                                                                                                                                                                                                          | 3. Time of Death<br><b>8:05 AM</b>                         |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not Institution, give street and number)<br><b>WESTWOOD NURSING HOME</b> |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |                                                                                                 |                                                             |                                                                                                                                                                                                          | 4c. County of Death<br><b>Montgomery</b>                   |                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br><b>578-50-4754</b>                                                |                                                                                                                                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.          |                                                                                                 | 8. Date of Birth (Month, Day, Year)<br><b>June 26, 1906</b> |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>Belgium</b> |                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Usual Residence of Decedent                                                                    |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                | 10b. County<br><b>Montgomery</b>                                                                                                                      |                                                                                | 10c. City, Town or Location<br><b>Bethesda</b>                                                                                                                                                                                                                                                          |                                                           |                                                                                                 |                                                             | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |                                                            |                                                                                  |  |
| 10e. Street and Number<br><b>5101 Ridgefield Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                                                                                                                                       |                                                                                | 10f. Zip Code<br><b>20816</b>                                                                                                                                                                                                                                                                           |                                                           |                                                                                                 |                                                             | 10g. Citizen of What Country?<br><b>Belgium</b>                                                                                                                                                          |                                                            |                                                                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                        |                                                           |                                                                                                 |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                  |                                                            |                                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |                                                                                                                                                       |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>                                                                                                                                                                           |                                                           |                                                                                                 |                                                             | 16b. Kind of Business/Industry<br><b>Embassy of Belgium</b>                                                                                                                                              |                                                            |                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Gustav Fleran</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |                                                                                                                                                       |                                                                                | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Angele Van Den Broecke</b>                                                                                                                                                                                                                        |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Alec Toumayan / son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                |                                                                                                                                                       |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6309 Newburn Dr. Bethesda, MD 20816</b>                                                                                                                                                             |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                               |                                                                                | 20c. Location - City or Town, State<br><b>Alex., Virginia</b>                                                                                                                                                                                                                                           |                                                           | 20d. Date<br><b>July 6, 2000</b>                                                                |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |                                                                                                                                                       |                                                                                | 22. Name and Address of Facility<br><b>DeVol Funeral Home<br/>2222 Wisconsin Ave., N.W.<br/>Washington, D.C. 20007</b>                                                                                                                                                                                  |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>b. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            | Approximate Interval Between Onset and Death<br><b>20 yrs.</b><br><b>20 yrs.</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pancytopenia</b><br><b>Hypothyroid</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                                                                 |                                                             | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                            |                                                                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                |                                                                                                                                                       |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                 |                                                                                | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                         |                                                           | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                             | 28d. Describe how injury occurred                                                                                                                                                                        |                                                            |                                                                                  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                            |                                                                                                |                                                                                                                                                       |                                                                                | 29b. Signature and title of certifier<br>                                                                                                                                                                            |                                                           |                                                                                                 |                                                             | 29c. License number<br><b>D0028873</b>                                                                                                                                                                   |                                                            |                                                                                  |  |
| 29d. Data signed (Month, Day, Year)<br><b>July 5, 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sharyn S. Horwitz, M.D. 10215 Fernwood Rd. Suite 100 Bethesda, MD 20817</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                | 32. Registrar's Signature<br>                                     |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                           |                                                                                                 |                                                             |                                                                                                                                                                                                          |                                                            |                                                                                  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23475

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Nancy A. Floyd                                    |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             | 2. Date of Death<br>Month Day Year<br>July 7 2000        |                                                                                                                                                                                                          |                                                     | 3. Time of Death<br>6:25am                                                                                                                             |                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Montgomery General Hospital |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             | 4b. City, Town, or Location of Death<br>Olney            |                                                                                                                                                                                                          |                                                     | 4c. County of Death<br>Montgomery                                                                                                                      |                                                                                                    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>578864437                                                        |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>41 Yrs.                                                                                                                                                        |                                                                                                                                             | 8. Date of Birth (Month, Day, Year)<br>September 6, 1958 |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Unknown |                                                                                                                                                        |                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                   |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               | 10b. County<br>Montgomery |                                                                                                                                                       | 10c. City, Town or Location<br>Bethesda                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |
| 10e. Street and Number<br>10500 West Lake Drive Apt. 104                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 10f. Zip Code<br>20817                                                                                                                      |                                                          | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |                                                     |                                                                                                                                                        |                                                                                                    |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |                                                                                               |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                             |                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                     |                                                                                                                                                        |                                                                                                    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)                                                                                                                                                                                                                                                                                                             |                                                                                               |                           |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Administrator                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                                                             |                                                          | 16b. Kind of Business/Industry<br>Computer                                                                                                                                                               |                                                     |                                                                                                                                                        |                                                                                                    |
| 17. Father's Name (First, Middle, Last)<br>Unknown                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown                                                                                |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |
| 19a. Informant's Name/Relationship (Type, Print)<br>Bryan Roecklein / Power of Attorney                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>230 Catherine Street Philadelphia PA 19147 |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |                                                                                               |                           |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Anatomic Gift Foundation                                                                                                                                                                                                      |                                                                                                                                                                                                  | Date<br>7/7/00                                                                                                                              |                                                          | 20c. Location - City or Town, State<br>Laurel, MD                                                                                                                                                        |                                                     |                                                                                                                                                        |                                                                                                    |
| 21. Signature of Funeral Service Licensee<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                           |                                                                                                                                                       | 22. Name and Address of Facility<br>Anatomic Gift Foundation<br>13948 Baltimore Avenue Laurel MD 20707                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Metastatic Breast Cancer<br>Due to (or as a consequence of):                                                                                         |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     | Approximate Interval Between Onset and Death<br>3 YEARS                                                                                                |                                                                                                    |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):                                                                                                                                                           |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             |                                                          | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                     |                                                                                                                                                        |                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             |                                                          | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                               |                           |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                               |                           |                                                                                                                                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  | 28b. Time of Injury<br>M                                                                                                                    |                                                          | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                     | 28d. Describe how injury occurred                                                                                                                      |                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                           |                                                                                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                                                                                                                                             |                                                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                             |                                                     |                                                                                                                                                        |                                                                                                    |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                               |                           |                                                                                                                                                       | 29b. Signature and title of certifier<br>[Signature]                                                                                                                                                                                                                                                    |                                                                                                                                                                                                  |                                                                                                                                             |                                                          | 29c. License number<br>D35635                                                                                                                                                                            |                                                     | 29d. Date signed (Month, Day, Year)<br>July 7, 2000                                                                                                    |                                                                                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Karam 1811 Penna Philip Dr Olney, MD 20832                                                                                                                                                                                                                                                                                        |                                                                                               |                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |
| 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                           |                                                                                                                                                       | 32. Registrar's Signature<br>[Signature]                                                                                                                                                                                                                                                                |                                                                                                                                                                                                  |                                                                                                                                             |                                                          |                                                                                                                                                                                                          |                                                     |                                                                                                                                                        |                                                                                                    |



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State of Maryland / Department of Health and Mental Hygiene 00 23476

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Roderic L. Fowler                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     | 2. Date of Death<br>Month Day Year<br>July 11, 2000                                                                                               |                                                                                                 |                                                                                                  | 3. Time of Death<br>4:40 AM                                |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>Washington Adventist Hospital                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     | 4b. City, Town, or Location of Death<br>Takoma Park                                                                                               |                                                                                                 |                                                                                                  | 4c. County of Death<br>Montgomery                          |  |
| Funeral<br>Director                           | 5. Social Security Number<br>242-43-6183                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>32 Yrs.                                                                                                                                                           |                                                                                                                                                   | 8. Date of Birth (Month, Day, Year)<br>Sept. 20, 1967                                           |                                                                                                  | 9. Birthplace (State or Foreign Country)<br>Washington, DC |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     | 10c. City, Town or Location<br>Silver Spring                                                                                                      |                                                                                                 | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                            |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. County<br>Montgomery                                                                                                                                                                                                                                                                               |  | 10e. Street and Number<br>11443 Columbia Pike #B-1                                                                                                                                                  |                                                                                                                                                   | 10f. Zip Code<br>20904                                                                          |                                                                                                  | 10g. Citizen of What Country?<br>United States             |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                   |                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>African American<br>Specify:                   |                                                            |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Employment Specialist                                                                                                                                                                      |  |                                                                                                                                                                                                     | 16b. Kind of Business/Industry<br>Human Resources Management                                                                                      |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | 17. Father's Name (First, Middle, Last)<br>Dr. Leon Fowler, Jr.                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br>Kay Onell Scott                                                                              |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Janet Morgan Fowler/ Wife                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11443 Columbia Pike #B1, Silver Spring, MD 20904 |                                                                                                 |                                                                                                  |                                                            |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland National                                                                                                                                                                                                             |  | Date<br>7/15/00                                                                                                                                                                                     |                                                                                                                                                   | 20c. Location - City or Town, State<br>Laurel, Maryland                                         |                                                                                                  |                                                            |  |
|                                               | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                     |  | 22. Name and Address of Facility<br>McGuire Funeral Service, Inc.<br>7400 Georgia Ave. N.W., Washington, D.C. 20012                                                                                                                                                                                     |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | Immediate Cause (Final disease or condition resulting in death)<br>a. Respiratory Arrest<br>Due to (or as a consequence of):<br>Pulmonary Embolism<br>b. Deep Vein Thrombosis<br>Due to (or as a consequence of):<br>c. d.                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Asthma<br>Crohn's disease                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                      |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                              |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |  | 28b. Time of Injury<br>M                                                                                                                                                                            |                                                                                                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                  | 28d. Describe how injury occurred                          |  |
|                                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
| State Registrar                               | 29b. Signature and title of certifier<br>Allen Brimmer                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     | 29c. License number<br>D 25914                                                                                                                    |                                                                                                 | 29d. Date signed (Month, Day, Year)<br>July 14, 2000                                             |                                                            |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Allen Brimmer, M.D. 12201 Plum Orchard Drive, Silver Spring, Maryland 20904                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |
|                                               | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                              |  | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                     |                                                                                                                                                   |                                                                                                 |                                                                                                  |                                                            |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23477

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Cora G. Fyfe

2. Date of Death

Month Day Year  
July 9 2000

3. Time of Death

5:30AM

4a. Facility Name (If not institution, give street and number)

Manor Care Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

578-16-1588

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 16, 1905

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10201 Sundance Ct.

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Office

17. Father's Name (First, Middle, Last)

Darius Gaskins

18. Mother's Name (First, Middle, Maiden Surname)

Cora Geiger

19a. Informant's Name/Relationship (Type, Print)

Corinne Rafferty/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10201 Sundance Ct., Potomac, MD 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory Inc. 7-11-2000 Beltsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Laura C. Hardisty

22. Name and Address of Facility

Rapp Funeral and Cremation Services  
Stephen D. Lohrmann P.A.  
933 Gist Ave. Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Atherosclerotic vascular disease  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bipolar disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Grady

29c. License number

D-0038781

29d. Date signed (Month, Day, Year)

7/10/00

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

4910 Massachusetts Ave NW #210 Washington, DC 20016-4300

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 11 2000

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23478

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rebecca Hallowell Faxon

2. Date of Death

June 25, 2000

3. Time of Death

9:20 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Heron Point Care Unit

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

039-12-3366

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

October 8, 1910

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

433 Heron Point

10f. Zip Code

21620

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic / Own Home

17. Father's Name (First, Middle, Last)

Robert H. Hallowell

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Nelson

19a. Informant's Name/Relationship (Type, Print)

Sarah Faxon Houlihan - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7740 Country Club Lane, Chestertown, Maryland 21620

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center, LLC

Date

June 26, 2000

20c. Location - City or Town, State

Stevensville, Maryland

21. Signature of Funeral Service Licensee

William L. King, Jr.

M-00937

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.  
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

b. Chronic obstructive lung disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Resection of lung cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marisa Friscia M.D.

29c. License number

D0054780

29d. Date signed (Month, Day, Year)

6/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marisa Friscia M.D., 122 Speer Road, Chestertown, MD 21620

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23479

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian Fitchett

2. Date of Death

Month

Day

Year

3. Time of Death

7

3

00

6 pm

4a. Facility Name (If not institution, give street and number)

St. Agnes MS &amp; Reh. Ctr.

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

127122152

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 17, 1898

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6155 Good Hunters Ride

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Grant Smith

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Mapp

19a. Informant's Name/Relationship (Type, Print)

Brenda Mapp Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6155 Good Hunters Side Columbia, Md. 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel A.M.E. Church

Date

7/8/00

20c. Location - City or Town, State

Eastville, Virginia

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

John O. Morris

P.O. Box 175 Nassawadox, Va. 23413

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CEREBROVASCULAR

Disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Thrombocytopenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D28595

29d. Date signed (Month, Day, Year)

7/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JASHEEM LAKHANI, 7220 PARK HEIGHTS AVE, BALD MD

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

[Signature]

91208

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Aug 20 - 1914

St. Louis, Mo.

Dear Mr. [illegible]

I have just received your letter of the 19th

and am glad to hear from you.

[The remainder of the letter is extremely faint and illegible.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23480

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br><b>Edward Maurice Ford, Jr.</b>           |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             | 2. Date of Death<br>Month Day Year<br><b>July 8 2000</b>                |                                                                                                | 3. Time of Death<br><b>1:14 PM</b>      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore VA</b> |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore city</b>           |                                                                                                | 4c. County of Death<br><b>Baltimore</b> |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br><b>213-38-2428</b>                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>60</b> | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                                                                                                     | 8. Date of Birth (Month, Day, Year)<br><b>Nov 4, 1939</b>                                   |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                    |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                           |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       | 10b. County<br><b>Howard</b>                                                                                                                                                                                                                                                                |                                             | 10c. City, Town or Location<br><b>Columbia</b>                                                                                                                                               |                                                                                                                                                    |                                                                                             |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                         |  |
| 10e. Street and Number<br><b>5021 W. Running Brook Rd</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             | 10f. Zip Code<br><b>21044</b>                                                                                                                                                                |                                                                                                                                                    | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                                         |                                                                                                |                                         |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                    |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic Maint. Eng.</b>                                                     |                                                                                                                                                    |                                                                                             | 16b. Kind of Business/Industry<br><b>Apartment Bldg.</b>                |                                                                                                |                                         |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Maurice Ford, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Theresa Marrissey</b>      |                                                                         |                                                                                                |                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth F. Bergen, Sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5104 Ella Court, Jefferson, MD 21755</b>                                                 |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resthaven Memorial Gdns.</b>                                                                                    |                                                                                                                                                    | Date<br><b>Jul 11, 00</b>                                                                   |                                                                         | 20c. Location - City or Town, State<br><b>Frederick, MD 21755</b>                              |                                         |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             | 22. Name and Address of Facility<br><b>Skkot Cody, Mortician</b><br><b>604 Admiral Drive #451 Annapolis, MD 21401</b>                                                                        |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Stage 4 Lung Adenocarcinoma</b><br>(Due to (or as a consequence of))<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                             | 28b. Time of Injury<br>M                                                                                                                                                                     |                                                                                                                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                              |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                             |                                                                                                                                                                                              |                                                                                                                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                         |                                                                                                |                                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                         |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 29b. Signature and title of certifier<br><br><b>RESIDENT PHYSICIAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             | 29c. License number<br><b>P09882</b>                                                                                                                                                         |                                                                                                                                                    | 29d. Date signed (Month, Day, Year)<br><b>July 8, 2000</b>                                  |                                                                         |                                                                                                |                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer Morran, 225. Greene Street, Dept of Internal Medicine, Baltimore, MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                                                                                                                                                                                                                                                             |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                             |                                                                                                                                                                                              |                                                                                                                                                    |                                                                                             |                                                                         |                                                                                                |                                         |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23481

Amended item#26,29d FCHD,KS 7/11/2000

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        |                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>David William Fitzgibbons</b>                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                   |                                                  |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>July</b> Day <b>10</b> , Year <b>2000</b> |                                                                                                                                                                                                                                                                         | 3. Time of Death<br><b>7:10 AM</b>                                                                         |                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>7432 Round Hill Rd.</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                   |                                                  |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Frederick</b>               |                                                                                                                                                                                                                                                                         | 4c. County of Death<br><b>Frederick</b>                                                                    |                                                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>272-05-8087</b>                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                         | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 3, 1910</b>                                                                                                                                                                                                              |                                                                                                            | 9. Birthplace (State or Foreign country)<br><b>New York</b>                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        |                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                             |
| 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><b>Frederick</b>                                                                                                                   |                                                  | 10c. City, Town or Location<br><b>Frederick</b>                                                                                                                                              |                                                                        |                                                                                                                                                                                                                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No             |                                                                                             |
| 10e. Street and Number<br><b>102 Mercer Ct.</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  | 10f. Zip Code<br><b>21701</b>                                                                                                                                                                |                                                                        | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                          |                                                                                                            |                                                                                             |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                        |                                                                                                                                                                                                                                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                    |                                                                                             |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>president and ceo</b>                                                        |                                                                        |                                                                                                                                                                                                                                                                         | 16b. Kind of Business/Industry<br><b>construction co.</b>                                                  |                                                                                             |
| 17. Father's Name (First, Middle, Last)<br><b>David Fitzgibbons</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Ferrell</b>                                                                                                                    |                                                                        |                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                             |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Louise V. Thompson (Friend)</b>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7432 Round Hill Rd., Frederick, MD. 21702</b>                                            |                                                                        |                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                             |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery</b>                                                                                         |                                                                        | Date<br><b>7/15</b>                                                                                                                                                                                                                                                     |                                                                                                            | 20c. Location - City or Town, State<br><b>Little Falls, N. Y.</b>                           |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  | 22. Name and Address of Facility<br><b>Donald B. Thompson Funeral Home<br/>31 E. Main St., Middletown, MD. 21769</b>                                                                         |                                                                        |                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                             |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>HEPATIC FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>HEPATIC METASTASES</b><br>Due to (or as a consequence of):<br>c. <b>ADENOCARCINOMA OF COLON</b><br>Due to (or as a consequence of):<br>d. |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        |                                                                                                                                                                                                                                                                         | Approximate Interval Between Onset and Death<br><b>1 MONTH</b><br><b>1 1/2 YEARS</b><br><b>1 1/2 YEARS</b> |                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        |                                                                                                                                                                                                                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      |                                                                                             |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                       |                                                                                                            |                                                                                             |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Friends Residence</b>                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                                                                            |                                                                                             |
| 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                         |                                                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred<br><b>Residence</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                            |                                                                                                            |                                                                                             |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        |                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                             |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        | 29c. License number<br><b>031761</b>                                                                                                                                                                                                                                    |                                                                                                            | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>                                 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BRIAN M. O'CONNOR MD 501 W. SEVENTH ST., FREDERICK, MD 21701</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                        |                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                             |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   | 32. Registrar's Signature<br>                    |                                                                                                                                                                                              |                                                                        |                                                                                                                                                                                                                                                                         |                                                                                                            |                                                                                             |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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State of Maryland / Department of Health and Mental Hygiene

00 23482

## Certificate of Death

Reg. No.

|                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                           |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>LUCY VIRGINIA GARNER</b>                                                                                                                                                                                                                                                                                                                                                   |                               |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month Day Year<br><b>July 12, 2000</b>                                                                                                                                   |  | 3. Time of Death<br><b>5:15 PM</b>                                                             |  |
|                                                                                                                                                    | 4e. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>                                                                                                                                                                                                                                                                                                                                |                               |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                                                                                                                                      |  | 4c. County of Death<br><b>Montgomery</b>                                                       |  |
| Funeral<br>Director                                                                                                                                | 5. Social Security Number<br><b>220-38-0826</b>                                                                                                                                                                                                                                                                                                                                                                           |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>July 29, 1908</b>                                    |  |
|                                                                                                                                                    | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                               | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                     |  | 10b. County<br><b>Montgomery</b>                                                                                                                                                             |  | 10c. City, Town or Location<br><b>Bethesda</b>                                                 |  |
| To Be Completed by Funeral Director                                                                                                                | 10e. Street and Number<br><b>7512 Sebago Road</b>                                                                                                                                                                                                                                                                                                                                                                         |                               | 10f. Zip Code<br><b>20817</b>                                                                                                                                                                                                                                                               |  | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                        |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                    | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|                                                                                                                                                    | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>                                                                                                                                                                                                                                                                                            |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Secretary</b>                                                                                                                                                     |  | 16b. Kind of Business/Industry<br><b>N.I.H.</b>                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                                    | 17. Father's Name (First, Middle, Last)<br><b>James William Kerr</b>                                                                                                                                                                                                                                                                                                                                                      |                               |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Voltz</b>                                                                                                                   |  |                                                                                                |  |
|                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Alan Garner (Son)</b>                                                                                                                                                                                                                                                                                                                                      |                               |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11051 Lockhart Lane Orlean, VA 20128</b>                                                 |  |                                                                                                |  |
|                                                                                                                                                    | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>National Crematory</b>                                                                                                                                                                                         |  | 20c. Location - City or Town, State<br><b>07-15 Falls Church, VA</b>                                                                                                                         |  |                                                                                                |  |
|                                                                                                                                                    | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                             |                               | 22. Name and Address of Facility<br><b>JOSEPH GAWLER'S SONS</b><br><b>5130 Wisconsin Ave., NW Washington, DC 20016</b>                                                                                                                                                                      |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>URINARY TRACT. INFECTION</b><br>Due to (or as a consequence of):<br><b>ADVANCED PARKINSON'S DISEASE</b><br>Due to (or as a consequence of):       |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                                    | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                           |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |
| Physician<br>/Medical<br>Examiner                                                                                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL INSUFFICIENCY</b><br><b>DEHYDRATION</b><br><b>ADVANCED PARKINSON'S DISEASE</b>                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                                    | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                               | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                                    | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                             |                               | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|                                                                                                                                                    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                              |  |                                                                                                |  |
| State<br>Registrar                                                                                                                                 | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                                    | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                 |                               |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>D. 17656</b>                                                                                                                                                       |  | 29d. Date signed (Month, Day, Year)<br><b>07/12/00</b>                                         |  |
|                                                                                                                                                    | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TIPAPORN WOODWARD, M.D. 5530 WISCONSIN AVE #550 CHRY CHASE, MD.</b>                                                                                                                                                                                                                                                            |                               |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                                |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 23483

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br>Genevieve I. Goulet                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br>July 1, 2000 |                                                                                      |                                                      |                                                                                                                                                                                                          | 3. Time of Death<br>1:45 PM                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br>Montgomery General Hospital |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br>Olney      |                                                                                      |                                                      |                                                                                                                                                                                                          | 4c. County of Death<br>Montgomery                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br>139-30-7193                                                      |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>85 Yrs.          |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Oct. 21, 1914 |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               | 10b. County<br>Montgomery                                                                                                                                                                                                                                                                               |                                                                                | 10c. City, Town or Location<br>Rockville                                                                                                                                                         |                                                    |                                                                                      |                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                          |  |
| 10e. Street and Number<br>4921 Sweetbitch Drive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 10f. Zip Code<br>26853                                                                                                                                                                           |                                                    | 10g. Citizen of What Country?<br>United States                                       |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                    |                                                                                      |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher                                                                             |                                                    |                                                                                      |                                                      | 16b. Kind of Business/Industry<br>Education                                                                                                                                                              |                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Louis N. Naglak                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Tillie Karp                                                                                                                                 |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Marie Goulet Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4921 Sweetbitch Drive, Rockville, MD 26853                                                      |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Our Lady of Sorrows Cem                                                                                                                                                                                                       |                                                                                | 20c. Location - City or Town, State<br>Finchhill, PA                                                                                                                                             |                                                    | 20d. Date<br>Jul 7, 2000                                                             |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br>Metropolitan Funeral Service, Inc.<br>5517 Vine Street Alexandria, VA 22310                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Cardiogenic Shock</i></p> <p>b. <i>Asystolic Event (Sudden Death)</i></p> <p>c. <i>Metabolic Acidosis</i></p> <p>d. </p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p>1 day</p> <p>1 day</p> <p>1 Day</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Parkinson's Disease</i><br><i>Dementia</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                          |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                  |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how injury occurred                                                                                                                                                                        |                                                          |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 29c. License number<br>D51908                                                                                                                                                                    |                                                    | 29d. Date signed (Month, Day, Year)<br>July 1 2000                                   |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Don B. Magliaro MD 1814 Prince Phillip Drive Suite 327 Olney, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                          |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

2. The second part of the paper is devoted to a discussion of the experimental results of the study of the structure of the atom. It is shown that the experimental results are in good agreement with the theoretical predictions of the theory of the structure of the atom.

3. The third part of the paper is devoted to a discussion of the applications of the theory of the structure of the atom. It is shown that the theory of the structure of the atom has many important applications in the field of physics and chemistry.

4. The fourth part of the paper is devoted to a discussion of the future of the theory of the structure of the atom. It is shown that the theory of the structure of the atom is still in the early stages of development, and that there are many important problems that need to be solved in the future.



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State of Maryland / Department of Health and Mental Hygiene

00 23484

Amend #1, 7/19/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><u>Catherine Greco</u>                                 |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <u>July</u> Day <u>9</u> Year <u>2000</u> |                                                                                                                                                                                              | 3. Time of Death<br><u>8:05am</u>    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><u>Sunrise Retirement Center</u> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><u>Columbia</u>             |                                                                                                                                                                                              | 4c. County of Death<br><u>Howard</u> |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><u>577-16-8247</u>                                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><u>80</u> Yrs.                    | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br><u>Jul. 17, 1919</u>                                        |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><u>England</u>          |                                                                                                                                                                                              |                                      |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                      |
| 10a. State<br><u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    | 10b. County<br><u>Howard</u>                                                                                                                                                                                                                                                                |                                                                     | 10c. City, Town or Location<br><u>Columbia</u>                                                                                                                                               |                                      |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                      |
| 10e. Street and Number<br><u>6500 Freetown Rd.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                    | 10f. Zip Code<br><u>21044</u>                                                                                                                                                                                                                                                               |                                                                     | 10g. Citizen of What Country?<br><u>USA</u>                                                                                                                                                  |                                      |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                      |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                      |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Head Teller</u>                                                                                                                                                             |                                                                     | 16b. Kind of Business/Industry<br><u>Bank</u>                                                                                                                                                |                                      |
| 17. Father's Name (First, Middle, Last)<br><u>Leyland Smith</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Alice Steele</u>                                                                                                                                                                                                                    |                                                                     |                                                                                                                                                                                              |                                      |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>George Greco/ Son</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3711 King Arthur Rd. Annandale, VA 22003</u>                                                                                                                                            |                                                                     |                                                                                                                                                                                              |                                      |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>National Mem. Park</u>                                                                                                                                                                                         |                                                                     | 20c. Location - City or Town, State<br><u>Jul. 11, 2000 Falls Church, VA</u>                                                                                                                 |                                      |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                    | 22. Name and Address of Facility<br><u>National Funeral Home</u><br><u>7482 Lee Hwy Falls Church, VA 22042</u>                                                                                                                                                                              |                                                                     |                                                                                                                                                                                              |                                      |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <u>Cardiomyopathy</u><br>Due to (or as a consequence of):<br><br>b. <u>Coronary artery Atherosclerosis</u><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |                                                                                                    | Approximate Interval Between Onset and Death<br><br><u>years</u><br><br><u>years</u>                                                                                                                                                                                                        |                                                                     |                                                                                                                                                                                              |                                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic obstructive pulmonary disease</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                 |                                                                     |                                                                                                                                                                                              |                                      |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                     |                                                                                                                                                                                              |                                      |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                     |                                                                                                                                                                                              |                                      |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                     | 28b. Time of Injury<br><u>M</u>                                                                                                                                                              |                                      |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                    | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                     | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                      |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                               |                                                                                                    | 29b. Signature and title of certifier<br><br><u>mo</u>                                                                                                                                                                                                                                      |                                                                     | 29c. License number<br><u>00038252</u>                                                                                                                                                       |                                      |
| 29d. Date signed (Month, Day, Year)<br><u>07/09/2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Andrew Farb 11085 Little Patuxent Parkway, Columbia MD, 21044</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                      |
| 31. Date filed (Month, Day, Year)<br><u>JUL 14 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                                     |                                                                                                                                                                                              |                                      |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





00 23485

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23486

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>James Greene</b>                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           | 2. Date of Death<br>Month <b>July</b> Day <b>10</b> Year <b>2000</b>                                                                                                                         |                                                                                             |                                                              |                                                                                                                                                                                                  | 3. Time of Death<br><b>4:40 PM</b>                         |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>                                                                                                                                 |                                                                                             |                                                              |                                                                                                                                                                                                  | 4c. County of Death<br><b>Montgomery</b>                   |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>216-11-8267</b>                                              |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.                                                                                                                                             |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 3, 1915</b>   |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>Antigua</b> |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 10a. State<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              | 10b. County<br><b>Montgomery</b>                                                                                                                                                                                                                                                            |                                                                                                                                                   | 10c. City, Town or Location<br><b>Silver Spring</b>                                                                       |                                                                                                                                                                                              |                                                                                             |                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                                            |                                              |  |
| 10e. Street and Number<br><b>555 Thayer Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 10f. Zip Code<br><b>20910</b>                                                                                             |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>Antigua</b>                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             |                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                          |                                                            |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Labor</b> |                                                                                                                                                                                              |                                                                                             | 16b. Kind of Business/Industry<br><b>Antigua Gov't.</b>      |                                                                                                                                                                                                  |                                                            |                                              |  |
| 17. Father's Name (First, Middle, Last)<br><b>Samuel Greene</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Appleton</b>                                                                                                                   |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ismay M. Greene (Wife)</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>555 Thayer Ave. Apt. 104 Silver Spring, Md. 20910</b>                                    |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                              |                                                                                              |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chambers Crematory</b>                                               |                                                                                                                           | Data<br><b>7/12/00</b>                                                                                                                                                                       |                                                                                             | 20c. Location - City or Town, State<br><b>Riverdale, Md.</b> |                                                                                                                                                                                                  |                                                            |                                              |  |
| 21. Signature of Funeral Service Licensee<br><b>Thomas S. Chambers # 670</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           | 22. Name and Address of Facility<br><b>Chambers Funeral Homes, P.A.<br/>5801 Cleveland Ave. Riverdale, Md. 20737</b>                                                                         |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            | Approximate Interval Between Onset and Death |  |
| a. <b>Sepsis</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            | 1 day                                        |  |
| b. <b>Pneumonia</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            | 1 Week                                       |  |
| c.<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| d.<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                            |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                            |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                            |                                              |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                         |                                                                                              | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                                                                           |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                              | 28d. Describe how injury occurred                                                                                                                                                                |                                                            |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 29b. Signature and title of certifier<br><b>Amendurillo MD</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           | 29c. License number<br><b>D38262</b>                                                                                                                                                         |                                                                                             | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>  |                                                                                                                                                                                                  |                                                            |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Mendhiratta 2401 Research Blvd. Suite 340 Rockville, Md. 20854</b>                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 13 2000</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                               |                                                                                                                                                   |                                                                                                                           |                                                                                                                                                                                              |                                                                                             |                                                              |                                                                                                                                                                                                  |                                                            |                                              |  |

THE CITY OF CHICAGO

OFFICE OF THE COMMISSIONER OF THE BOARD OF EDUCATION  
CHICAGO, ILLINOIS

TO THE HONORABLE THE BOARD OF EDUCATION  
CHICAGO, ILLINOIS

SUBJECT: [Illegible]

[The remainder of the page contains extremely faint, illegible text, likely a memorandum or official communication.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23487

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                          |  |                                                                                      |  |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Josephine Gray</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month <u>07</u> Day <u>05</u> Year <u>2000</u>                                                                                                                                       |  | 3. Time of Death<br><u>8:30 Am</u>                                                   |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><u>Harbor Hospital</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br><u>Baltimore City</u>                                                                                                                                            |  | 4c. County of Death<br><u>Baltimore</u>                                              |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>212-44-6183</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br><u>57</u> Yrs.                                                                                                                                                         |  | 8. Date of Birth (Month, Day, Year)<br><u>June 12, 1943</u>                          |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><u>Baltimore, MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10a. State<br><u>Maryland</u>                                                                                                                                                                                                                                                                           |  | 10b. County<br><u>Baltimore</u>                                                                                                                                                                          |  | 10c. City, Town or Location<br><u>Baltimore</u>                                      |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10e. Street and Number<br><u>202 West 3rd Avenue</u>                                                                                                                                                                                                                                                    |  | 10f. Zip Code<br><u>21225</u>                                                                                                                                                                            |  | 10g. Citizen of What Country?<br><u>USA</u>                                          |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                         |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>              |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Accountant</u>                                                                                                                                                                          |  | 16b. Kind of Business/Industry<br><u>Accounting</u>                                                                                                                                                      |  |                                                                                      |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><u>Grover C. Ward</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Florance Elsie Joiner</u>                                                                                                                        |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)<br><u>Connie Lee Smith</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>202 West 3rd Avenue, Baltimore, Maryland 21225</u>                                                   |  |                                                                                      |  |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Wesley Chapel Cemetery</u>                                                                                                                                                                                                 |  | Date<br><u>6/8/2000</u>                                                                                                                                                                                  |  | 20c. Location - City or Town, State<br><u>Rock Hall, Maryland</u>                    |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br><u>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A.<br/>130 Speer Road, Chestertown, Maryland 21620</u>                                                           |  |                                                                                      |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>possible sepsis</u><br>Due to (or as a consequence of):<br><br>b. <u>congestive heart failure</u><br>Due to (or as a consequence of):<br><br>c. <u>END STAGE RENAL DISEASE</u><br>Due to (or as a consequence of):<br><br>d. <u>Hypertension</u> |  |                                                                                                                                                                                                                                                                                                         |  | Approximate Interval Between Onset and Death<br><br><u>4 days</u><br><br><u>1-2 years</u><br><br><u>1-2 years</u><br><br><u>10 years</u>                                                                 |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetic MELLITUS</u><br><u>peripheral vascular Disease</u>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                                                                      |  |
|                                               | 24a. Was an autopsy performed?<br><u>1</u> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                          |  |                                                                                      |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                      |  | 28a. Date of Injury (Month, Day, Year)<br><u>June 12, 2000</u>                                                                                                                                                                                                                                          |  | 28b. Time of Injury<br><u>M</u>                                                                                                                                                                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                             |  |                                                                                      |  |
|                                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                  |  | 29b. Signature and title of certifier<br><u>[Signature] MD</u>                                                                                                                                                                                                                                          |  | 29c. License number<br><u>P12136</u>                                                                                                                                                                     |  | 29d. Date signed (Month, Day, Year)<br><u>July 05, 2000</u>                          |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>QING TRING-OLLEY, MD 3001 S. HANOVER ST. Baltimore, MD 21225</u>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                          |  |                                                                                      |  |
|                                               | 31. Date filed (Month, Day, Year)<br><u>JUL 11 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                          |  |                                                                                      |  |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23488

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET GREGORSKI

2. Date of Death

Month  
JulyDay  
4Year  
2000

3. Time of Death

0640

4a. Facility Name (If not Institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

191-18-0499

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

4/27/23

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

PA

10b. County

Lackawanna

10c. City, Town or Location

Olyphant

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

R.D. #2, Box 112

10f. Zip Code

18447

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Garment Industry

17. Father's Name (First, Middle, Last)

Edward Lutchko

18. Mother's Name (First, Middle, Maiden Surname)

Mary Kupchak

19a. Informant's Name/Relationship (Type, Print)

Gale Sokoloski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 195, R.D.#2, Olyphant, PA 18447

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph's Cemetery

Date

7/8/00

20c. Location - City or Town, State

Justus, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home

108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Acute Myocardial Infarction*

Due to (or as a consequence of):

b. *Hypertension*

Due to (or as a consequence of):

c. *Advanced Age*

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44413

29d. Date signed (Month, Day, Year)

July 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter Gianelle, MD 9733 Healthway Dr. Berlin, MD 21811

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

*[Signature]*State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23489

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Albert J. Giuffreda, Sr.            |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 7, 2000 |                                                                                                                                                                                                  |                                |                                                                                                    | 3. Time of Death<br>10:15 P.M.                                   |                                   |                                                            |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4e. Facility Name (If not institution, give street and number)<br>7 Dental Road |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Edgewater  |                                                                                                                                                                                                  |                                |                                                                                                    | 4c. County of Death<br>Anne Arundel                              |                                   |                                                            |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>577-32-4053                                        |                             | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>71 Yrs.          |                                                                                                                                                                                                  | If Under 1 Year<br>Months Days |                                                                                                    | 8. Date of Birth (Month, Day, Year)<br>July 31, 1928             |                                   | 9. Birthplace (State or Foreign Country)<br>Washington, DC |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                     |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                 | 10b. County<br>Anne Arundel |                                                                                                                                                       | 10c. City, Town or Location<br>Edgewater                                                                                                                                                                                                                                                                |                                                    |                                                                                                                                                                                                  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 10e. Street and Number<br>7 Dental Road                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                 |                             |                                                                                                                                                       | 10f. Zip Code<br>21037                                                                                                                                                                                                                                                                                  |                                                    |                                                                                                                                                                                                  |                                | 10g. Citizen of What Country?<br>USA                                                               |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |                                                                                 |                             | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         |                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |                                                            |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs.                                                                                                                                                                                                                                                                                                        |                                                                                 |                             |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesman                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                  |                                | 16b. Kind of Business/Industry<br>Washington Gas Co.                                               |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Antonio Giuffreda                                                                                                                                                                                                                                                                                                                                                                     |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br>Eugenia Pepe                                                                                                                                |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mary Giuffreda/ Wife                                                                                                                                                                                                                                                                                                                                                         |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7 Dental Road Edgewater, MD 21037                                                               |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |                                                                                 |                             |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery                                                                                                                                                                                                          |                                                    | Date<br>7-11-00                                                                                                                                                                                  |                                | 20c. Location - City or Town, State<br>Brentwood, Maryland                                         |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>2973 Solomons Island Rd. Edgewater, MD 21037                                                                                 |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                                  |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            | 6 weeks                                                                                                                                                                                                  |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            | 3 years                                                                                                                                                                                                  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                       |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                 |                             |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                              |                                                                                 |                             |                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                    | 28b. Time of Injury<br>M                                                                                                                                                                         |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                                  | 28d. Describe how injury occurred |                                                            |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                 |                             |                                                                                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                    |                                                                                                                                                                                                  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    | 29c. License number<br>D 21438                                                                                                                                                                   |                                |                                                                                                    | 29d. Date signed (Month, Day, Year)<br>July 09 2000              |                                   |                                                            |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MICHAEL J. LAFENIA 600 RIDGE LANE STE 120 ANNAPOLIS, MD 21401                                                                                                                                                                                                                                                                            |                                                                                 |                             |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 11 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |                             |                                                                                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                                                  |                                   |                                                            |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23490

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Christopher Charles Gonce, Jr.

2. Date of Death

Month Day Year  
July 18 2000

3. Time of Death

10:44pm

4a. Facility Name (If not institution, give street and number)

10814 Acme Avenue

4b. City, Town, or Location of Death

Granite

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215 23 7321

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

14 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 2, 1985

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Granite

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10814 Acme Avenue

10f. Zip Code

21163

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Christopher Charles Gonce, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Cheryl Ann Spiezio

19a. Informant's Name/Relationship (Type, Print)

Christopher C. Gonce Sr./Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10814 Acme Avenue Granite, Maryland 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Good Shepherd Cemetery 7-22-2000 Ellicott City, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ Stan A. Colbis-Wilke MD 101044

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Increased Intracranial Pressure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 mo

b.

Glioblastoma

Due to (or as a consequence of):

21 mo

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

▶ Cindy L. Schwartz

29c. License number

D28219

29d. Date signed (Month, Day, Year)

July 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cindy L. Schwartz, MD 600 N. Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JUL 20 2000

32. Registrar's Signature

▶ Penina B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2026.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





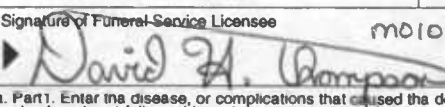
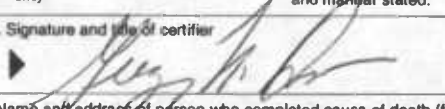
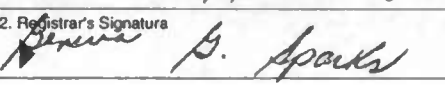
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23491

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES THOMAS GORDY</b>                       |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                 | 2. Date of Death<br>Month Day Year<br><b>July 6, 2000</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>10:53 AM</b>                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>802 Filmore Street</b> |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                 | 4b. City, Town, or Location of Death<br><b>Salisbury</b>  |                                                                                                                                                                                                  | 4c. County of Death<br><b>Wicomico</b>                                                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>215-20-1739</b>                                             |                                                                                                                                                                                                                                                                                                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                 | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.          |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>February 23, 1928</b>                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10a. State<br><b>Maryland</b>                                                               |                                                                                                                                                                                                                                                                                                        | 10b. County<br><b>Wicomico</b>                                             |                                                                                                                                                                                                 | 10c. City, Town or Location<br><b>Salisbury</b>           |                                                                                                                                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Army</b>                                                                                                                                          |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |                                                                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b><br>College (1-4 or 5+) <b>-</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter/Painter</b>                                                                                                                                                                  |                                                                            | 16b. Kind of Business/Industry<br><b>Construction</b>                                                                                                                                           |                                                           |                                                                                                                                                                                                  |                                                                                                |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Dale Gordy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hilda Whayland</b>                                                                                                                      |                                                           |                                                                                                                                                                                                  |                                                                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn M. Gordy/Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>802 Filmore St., Salisbury, MD 21804</b>                                                    |                                                           |                                                                                                                                                                                                  |                                                                                                |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parsons Cemetery</b>                                                                                                                                                                                                      |                                                                            | Data<br><b>7/10/00</b>                                                                                                                                                                          |                                                           | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>                                                                                                                                      |                                                                                                |  |
| 21. Signature of Funeral Service Licensee<br><br><b>David A. Thompson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             | 22. Name and Address of Facility<br><b>Holloway Funeral Home Professional Association</b><br><b>501 Snow Hill Rd., Salisbury, MD 21804</b>                                                                                                                                                             |                                                                            |                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |                                                                                             | Approximate Interval Between Onset and Death<br><b>5 MONTHS</b>                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                 |                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                 |                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                 |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                                                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                             |                                                                                             | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                  |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                 |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                 |                                                                            | 28d. Describe how injury occurred                                                                                                                                                               |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                           |                                                                                             | 29b. Signature and title of certifier<br><br><b>GREGORY THOMPSON</b>                                                                                                                                                |                                                                            | 29c. License number<br><b>10030734</b>                                                                                                                                                          |                                                           | 29d. Date signed (Month, Day, Year)<br><b>7/7/00</b>                                                                                                                                             |                                                                                                |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>GREGORY THOMPSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             | 31. Data filed (Month, Day, Year)<br><b>JUL 10 2000</b>                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                                                                |  |
| 32. Registrar's Signature<br><br><b>B. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             | 33. Data signed (Month, Day, Year)<br><b>PRMC STATION BOX 379 SALISBURY</b>                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                                  |                                                                                                |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 23492

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1. Decedent's Name (First, Middle, Last)<br>John Giga                                |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 10 2000  |                                                                                                    | 3. Time of Death<br>4:45 PM                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4a. Facility Name (If not institution, give street and number)<br>3206 Florence Road |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Woodbine    |                                                                                                    | 4c. County of Death<br>Howard                       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 5. Social Security Number<br>080-28-2955                                             |                       | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                        |                                                                                                                                      | 7. Age (In yrs. last birthday)<br>77 Yrs.                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br>Feb. 7, 1923 |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Ukraine |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Usual Residence of Decedent                                                          |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                     |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      | 10b. County<br>Howard |                                                                                                                                                       | 10c. City, Town or Location<br>Woodbine                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                     | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                     |  |
| 10e. Street and Number<br>3206 Florence Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   | 10f. Zip Code<br>21797                                                                                                                                                                                                                                                                                  |                                                     | 10g. Citizen of What Country?<br>United States                                                     |                                                     |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                                                                                                                         |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                       |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Building Superintendent |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 16b. Kind of Business/Industry<br>Real Estate       |                                                                                                    |                                                     |  |
| 17. Father's Name (First, Middle, Last)<br>Demitri Giga                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Eva Unknown                                                                                                                                                                                                                                        |                                                     |                                                                                                    |                                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ann Marie Madden / Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3206 Florence Road Woodbine, Maryland 21797                                                                                                                                                            |                                                     |                                                                                                    |                                                     |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                          |                                                                                      |                       |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hagerstown Crematory                                       |                                                                                                                                                                                                   | Date<br>7/12/00                                                                                                                                                                                                                                                                                         |                                                     | 20c. Location - City or Town, State<br>Hagerstown, Maryland                                        |                                                     |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   | 22. Name and Address of Facility<br>Stauffer Funeral Home, P.A.<br>8 E. Ridgeville Blvd., Mt. Airy, Maryland 21771                                                                                                                                                                                      |                                                     |                                                                                                    |                                                     |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CARDIOPULMONARY ARREST<br>Due to (or as a consequence of):<br>b. METASTATIC COLON CANCER<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>3 MINUTES<br>ONE YEAR |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC LUNG DISEASE                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                     |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                     |                                                                                                    |                                                     |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                |                                                                                      |                       |                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                |                                                                                                                                                                                                   | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                     |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                     |                                                                                                    |                                                     |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                         |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                     |  |
| 29b. Signature and Title of Certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   | 29c. License number<br>20565 (X)                                                                                                                                                                                                                                                                        |                                                     | 29d. Date signed (Month, Day, Year)<br>7/12/00                                                     |                                                     |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>R. Martin Bashir, MD 106 Irving St. NW, Washington DC 20010                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                    |                                                     |  |
| 31. Date filed (Month, Day, Year)<br>JUL 12 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                      |                       |                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                                                                   | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                     |                                                                                                    |                                                     |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Article 1  
Section 1

The purpose of this act is to provide for the better  
and more efficient administration of the public  
lands of the State.

Section 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23493

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br>Fay Goldman                                          |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 2. Date of Death<br>Month Day Year<br>June 26, 2000                                                                                                                                              |                       |                                                                                      |                                                                                                                                                                                                          | 3. Time of Death<br>4:45 PM                        |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 4b. City, Town, or Location of Death<br>ROCKVILLE                                                                                                                                                |                       |                                                                                      |                                                                                                                                                                                                          | 4c. County of Death<br>MONTGOMERY                  |                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br>052-32-4699                                                         |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |                                                                                                                               | 7. Age (In yrs. last birthday)<br>87 Yrs.                                                                                                                                                        |                       | 8. Date of Birth (Month, Day, Year)<br>Sep. 10, 1912                                 |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Russia |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                                      |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  | 10b. County<br>Montgomery |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br>Gaithersburg                                                                                   |                                                                                                                                                                                                  |                       |                                                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                    |                                                                  |  |
| 10e. Street and Number<br>8023 Lions Crest Way                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br>20879                                                                                                        |                                                                                                                                                                                                  |                       |                                                                                      | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                                                                  |                                                    |                                                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                       |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                    |                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Accounting Clerk |                                                                                                                                                                                                  |                       |                                                                                      | 16b. Kind of Business/Industry<br>Medical                                                                                                                                                                |                                                    |                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br>Max Yigdall                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Reizel Unknown                                                                                                                              |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mike Goldman/ Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8023 Lions Crest Way, Gaithersburg, MD 20879                                                    |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>New Montefiore Cemetery                                                                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  | Date<br>June 28, 2000 |                                                                                      | 20c. Location - City or Town, State<br>Farmingdale, NY                                                                                                                                                   |                                                    |                                                                  |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 22. Name and Address of Facility<br>Danzansky-Goldberg Memorial Chapels, Inc.<br>1170 Rockville Pike, Rockville, MD 20852                                                                        |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <u>Respiratory failure</u><br>Due to (or as a consequence of):<br>b. <u>Congestive heart failure</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      |                                                                                                                                                                                                          |                                                    | Approximate Interval Between Onset and Death<br>minutes<br>Hours |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                    |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                    |                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                   |                                                    |                                                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  |                           | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                               | 28b. Time of Injury<br>M                                                                                                                                                                         |                       | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          | 28d. Describe how injury occurred                  |                                                                  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                     |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
| 29b. Signature and title of certifier<br> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 29c. License number<br>D 31391                                                                                                                                                                   |                       |                                                                                      | 29d. Date signed (Month, Day, Year)<br>June 27, 2000                                                                                                                                                     |                                                    |                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Suhair Abulfarag, MD 481 N. Frederick Ave, #230 Gaithersburg, MD 20877                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUN 30 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  |                           | 32. Registrar's Signature<br>                                                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                       |                                                                                      |                                                                                                                                                                                                          |                                                    |                                                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 11 per fh G787 9/20/00 yf

## Certificate of Death

Reg. No.

00 23494

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Betty Louise Gunn

2. Date of Death

Month 6 Day 29 Year 2000

3. Time of Death

2:00pm

4a. Facility Name (If not institution, give street and number)

7613 Fontainebleau Drive # 2110

4b. City, Town, or Location of Death

New Carrollton Prince George

4c. County of Death

5. Social Security Number

578 58 1838

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8 7 43

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Md

10b. County

Prince George

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7613 Fontainebleau Drive

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk Typist

16b. Kind of Business/Industry

D.C. Government

17. Father's Name (First, Middle, Last)

Jesse J. Ferguson

18. Mother's Name (First, Middle, Maiden Summa)

Louise V. Taylor

19a. Informant's Name/Relationship (Type, Print)

Anthony Ferguson, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7613 Fontainebleau Dr. #2110 New Carrollton Md. 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park 7/7/00 Landover Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ruth C. Hall

22. Name and Address of Facility

HALL BROTHERS FUNERAL HOME  
621 Florida Avenue, NW, Wash. D.C. 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William J. Cullen

29c. License number

22174/DC

29d. Date signed (Month, Day, Year)

June 30, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William J. Cullen, M.D.

1011 North Capitol Street, N.E.  
Washington, D.C. 20002

31. Date filed (Month, Day, Year)

JUL 03 2000

Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

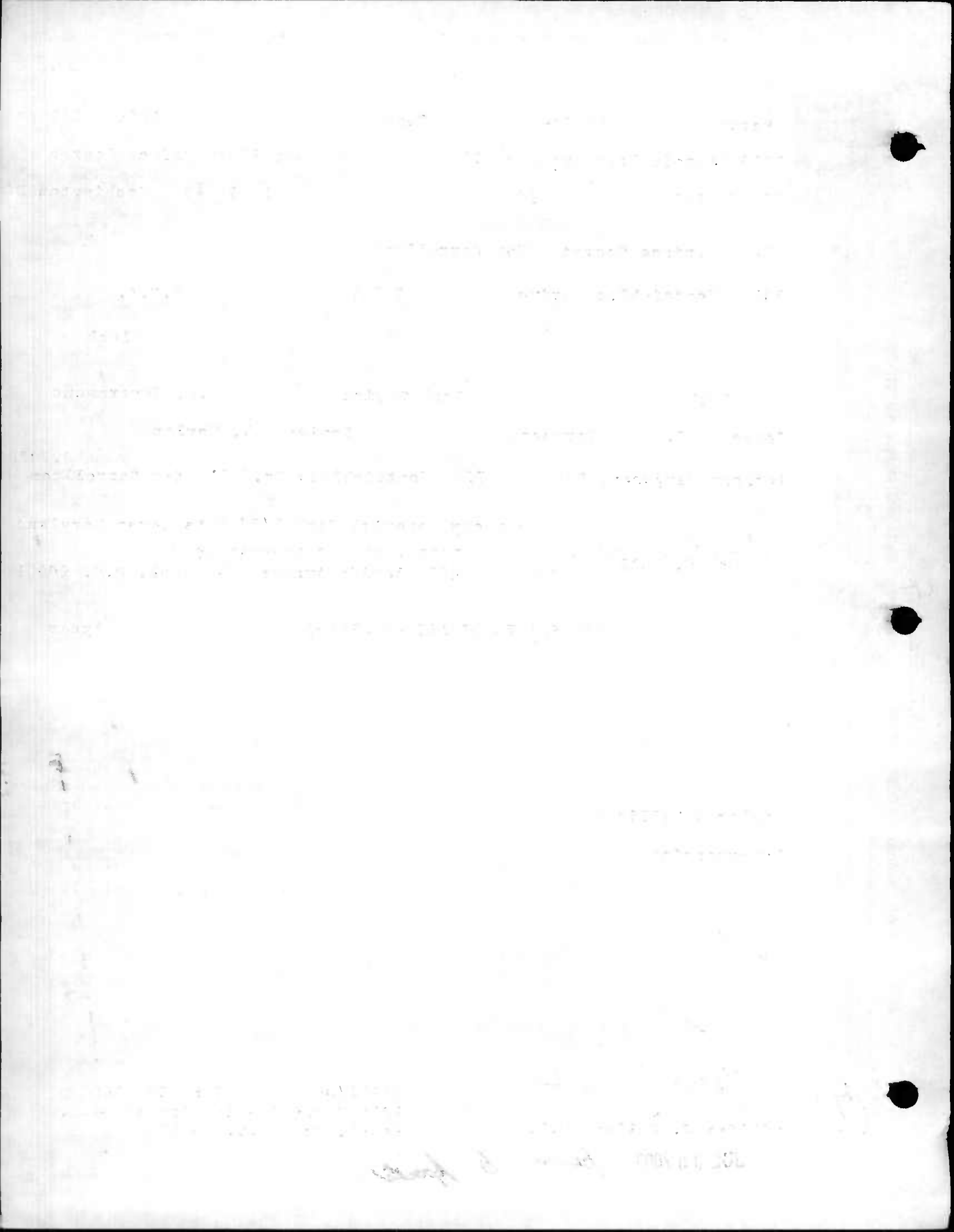
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 23495

## Certificate of Death

Reg. No.

|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Sarah Jane Harris                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>July 7, 2000                                                                                                                                               |  |                                                                                      |                                                                  | 3. Time of Death<br>6:25PM                                                                         |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 4a. Facility Name (If not institution, give street and number)<br>Suburban Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Bethesda                                                                                                                                                 |  |                                                                                      |                                                                  | 4c. County of Death<br>Montgomery                                                                  |  |                                                                                                                                                                                                          |  |                                                      |  |
| Funeral<br>Director                              | 5. Social Security Number<br>453-03-0714                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>88 Yrs.                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 20, 1912                                 |                                                                  | 9. Birthplace (State or Foreign Country)<br>Oklahoma                                               |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
| To Be Completed by Funeral Director              | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   | 10b. County<br>Montgomery                                                                                                                                                                                                                                                                               |  | 10c. City, Town or Location<br>Chevy Chase                                                                                                                                                       |  |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 10e. Street and Number<br>7206 Brennon Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br>20815                                                                                                                                                                           |  | 10g. Citizen of What Country?<br>United States                                       |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk Selective Services                                                            |  |                                                                                      | 16b. Kind of Business/Industry<br>U. S. Government               |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 17. Father's Name (First, Middle, Last)<br>Wilson Simon Sale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen Callaway                                                                                                                              |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
| To Be Completed by Physician/Medical Examiner    | 19a. Informant's Name/Relationship (Type, Print)<br>Victoria H. Jennings-Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7206 Brennon Lane, Chevy Chase, Maryland, 20815                                                 |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery                                                                                                                                                                                                             |  | Date<br>July 13, 2000                                                                                                                                                                            |  | 20c. Location - City or Town, State<br>Greenville, South Carolina                    |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 21. Signature of Funeral Service Licensee<br> M01126                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.<br>Bethesda, Maryland 20814-3501                                         |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Pneumonia, Right Lower Lobe<br><br>Due to (or as a consequence of):<br>Chronic Obstructive Pulmonary Disease<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Osteoporosis, Atrial Fibrillation<br>Chronic Renal Failure, Chronic Anemia |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  | Approximate Interval Between Onset and Death<br>24 Hours<br>years                                                                                                                                        |  |                                                      |  |
|                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>Osteoporosis, Atrial Fibrillation<br>Chronic Renal Failure, Chronic Anemia                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                                      |  |
| State Registrar                                  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                  |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
|                                                  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                            |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  | 29c. License number<br>D09764                                                                                                                                                                            |  | 29d. Date signed (Month, Day, Year)<br>July 12, 2000 |  |
|                                                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joel A. Raikin, MD 15215 Shady Grove Rd., Rockville, MD 20850                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |                                                      |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23496

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Bernadette Hemelt

2. Date of Death

Month Day Year  
July 9, 2000

3. Time of Death

9:15 pm

4a. Facility Name (If not institution, give street and number)

3500 Duke Street

4b. City, Town, or Location of Death

College Park

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-12-8791

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 30, 1916

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3500 Duke Street

10f. Zip Code

20740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Patrick Connor

18. Mother's Name (First, Middle, Maiden Surname)

Irene Letitia Smith

19a. Informant's Name/Relationship (Type, Print)

Anthony C. Hemelt / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3500 Duke Street, College Park, MD 20740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/13/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

TRACY A. STIVEN

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Malnutrition

Due to (or as a consequence of):

b. Mental Depression

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Essential Hypertension

Hypothyroidism

Osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Luis A. Heffess

29c. License number

D 19408

29d. Date signed (Month, Day, Year)

July 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Luis A. Heffess, MD 1160 Varnum Street, NE, Washington, DC 20017

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 11 2000

32. Registrar's Signature

Luis A. Heffess

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be dated for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 23497

Amend #31, see #32, 7/10/2000, BMW, Montg. Co.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Metta I. Hudson

2. Date of Death

Month  
July

Day

7

Year

2000

3. Time of Death

12:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Adventist Healthcare Sligo Creek Nursing

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

218-30-5313

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
July 24, 1909

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

8308 Flower Ave. #304

10f. Zip Code

20912

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nursing Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Irby Hudson

18. Mother's Name (First, Middle, Maiden Surname)

Cora Ann Marks

19a. Informant's Name/Relationship (Type, Print)

Ronald Hudson/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7328 Rolling Oak Lane Springfield, VA 22153

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Northern Virginia Crematory

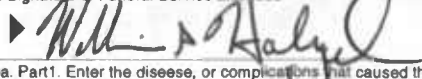
Date

07/09/00

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Takoma Funeral Home

254 Carroll St. NW Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIOPULMONARY FAILURE

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d. ACUTE MYOCARDIAL INFARCTION

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

H45839

29d. Date signed (Month, Day, Year)

7/7/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Gary Raffel 8609 Second Ave #401B Silver Spring, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

July 7 2000

32. Registrar's Signature

JUL 10 2000



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1945

January 1st

1945

February 1st

1945

1945

March 1st

1945

April 1st

1945

1945

May 1st

1945

1945

June 1st

1945

July 1st

August 1st

1945

September 1st

October 1st

November 1st

December 1st

1945

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 23498

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br>Barbara Keeley Hoy                                 |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      | 2. Date of Death<br>Month Day Year<br>June 18, 2000 |                                                                                                                                                                                                  |                                                        |                                                                                      | 3. Time of Death<br>1430                                         |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br>Kent & Queen Anne's Hospital |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      | 4b. City, Town, or Location of Death<br>Chestertown |                                                                                                                                                                                                  |                                                        |                                                                                      | 4c. County of Death<br>Kent                                      |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br>006-16-0652                                                       |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                      | 7. Age (In yrs. last birthday)<br>78 Yrs.           |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br>October 7, 1921 |                                                                                      | 9. Birthplace (State or Foreign Country)<br>Portland, Maine      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                         |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      | 10b. County<br>Kent                                 |                                                                                                                                                                                                  | 10c. City, Town or Location<br>Chestertown             |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                |  |                                                                                                                                                       | 10e. Street and Number<br>101 Manor Avenue                                                                                                                                                                                                                                                           |                                                     |                                                                                                                                                                                                  |                                                        | 10f. Zip Code<br>21620                                                               |                                                                  | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                      |                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                        |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |  |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                               |                                                     |                                                                                                                                                                                                  |                                                        | 16b. Kind of Business/Industry<br>Own home                                           |                                                                  |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph J. Keeley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |  |                                                                                                                                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br>Catherine Coppinger                                                                                                                                                                                                                             |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Murray K. Hoy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                |  |                                                                                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3589 Union Church Road, Salisbury, MD 21804                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |  |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Pauls Cemetery                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                        | Date<br>6/21/2000                                                                    |                                                                  | 20c. Location - City or Town, State<br>Chestertown, MD                                                                                                                                                   |  |
| 21. Signature of Funeral Service<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |  |                                                                                                                                                       | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>130 Speer Road, Chestertown, Maryland 21620                                                                                                                                                                   |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Sudden Death</u><br>Due to (or as a consequence of):<br>b. <u>Aortic Stenosis</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                                |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  | Approximate Interval Between Onset and Death<br><u>Minutes</u>                                                                                                                                           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>DIABETES Mellitus</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |  |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                    |                                                                                                |  |                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                |                                                     | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                        | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                                                                                                                        |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |  |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                              |                                                                                                |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                |  |                                                                                                                                                       | 29c. License number<br>D35043                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                                                                  |                                                        | 29d. Date signed (Month/Day, Year)<br>6/19/00                                        |                                                                  |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Eric F. Ciganec 2540 Centreville Road, Centreville, MD 21617                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |  |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUN 21 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                |  |                                                                                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                                    |                                                     |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Charles Edward Hurd                                |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        | 2. Date of Death<br>Month Day Year<br>July 8 2000   |                                                                                                                                                           | 3. Time of Death<br>1102                              |                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Kent & Queen Anne's Hospital |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        | 4b. City, Town, or Location of Death<br>Chestertown |                                                                                                                                                           | 4c. County of Death<br>Kent                           |                                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>216-40-4411                                                       |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                        | 7. Age (In yrs. last birthday)<br>58 Yrs.           |                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br>March 11, 1942 |                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. Birthplace (State or Foreign Country)<br>Chestertown, MD                                    |                                                                                                                                                                                                                                                                                                         | 10a. State<br>Maryland                                                         |                                                                                                                                                                                                                                                                                        | 10b. County<br>Kent                                 |                                                                                                                                                           | 10c. City, Town or Location<br>Chestertown            |                                      |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                      |                                                                                | 10e. Street and Number<br>23065 Old Fairlee Road                                                                                                                                                                                                                                       |                                                     | 10f. Zip Code<br>21620                                                                                                                                    |                                                       | 10g. Citizen of What Country?<br>USA |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                      |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                          |                                                       |                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Waterman                                                                                                                                                                                   |                                                                                | 16b. Kind of Business/Industry<br>Seafood                                                                                                                                                                                                                                              |                                                     |                                                                                                                                                           |                                                       |                                      |  |
| 17. Father's Name (First, Middle, Last)<br>John David Hurd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen Maislin                                                                                                                                                                                                                     |                                                     |                                                                                                                                                           |                                                       |                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Nancy Ada Hurd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>23065 Old Fairlee Road, Chestertown, Maryland 21620                                                                                                                                   |                                                     |                                                                                                                                                           |                                                       |                                      |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                               |                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chester Cemetery                                                                                                                                                                                                              |                                                                                | 20c. Date<br>7/12/2000                                                                                                                                                                                                                                                                 |                                                     | 20d. Location - City or Town, State<br>Chestertown, MD                                                                                                    |                                                       |                                      |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>130 Speer Road, Chestertown, Maryland 21620                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                           |                                                       |                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Coronary Artery Disease</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                              |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |                                                       |                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Transitional Cell Cancer of Bladder</u><br><u>Deep Vein Thrombosis</u>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                           |                                                       |                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |                                                     | 28a. Date of injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                       | 28d. Describe how injury occurred    |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                           |                                                       |                                      |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                               |                                                                                | 29c. License number<br>D005178                                                                                                                                                                                                                                                         |                                                     | 29d. Date signed (Month, Day, Year)<br>7/11/00                                                                                                            |                                                       |                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Andrew Ferguson MD 120 Speer Road Suite II Chestertown MD 21620                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                | 31. Date filed (Month, Day, Year)<br>JUL 12 2000                                                                                                                                                                                                                                                        |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                          |                                                     |                                                                                                                                                           |                                                       |                                      |  |



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State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death

Reg. No.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Michael Keith Hamill</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> Year <b>2000</b>                                                                                                                                                                                                                        |                                | 3. Time of Death<br><b>06:37 AM</b>                                                                                                                                                              |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                                                                                                                    |                                | 4c. County of Death                                                                                                                                                                              |
| 5. Social Security Number<br><b>212-56-7863</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   |
| 8. Date of Birth (Month, Day, Year)<br><b>April 29, 1951</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                 |                                |                                                                                                                                                                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10b. County<br><b>Baltimore</b>                                            | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                             |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |
| 10e. Street and Number<br><b>5509 Mattfeldt Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 10f. Zip Code<br><b>21209</b>                                                                                                                                                                                                                                                               |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)                                                                                                                                                                 |                                |                                                                                                                                                                                                  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 16b. Kind of Business/Industry<br><b>Automotive</b>                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>James B. Hamill</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret A. Caverly</b>                                                                                                                                                                                                             |                                |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Margaret A. Hamill (mother)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5509 Mattfeldt Avenue Baltimore, MD 21209</b>                                                                                                                                           |                                |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation Serv.</b>                                                                                                                                                                                 |                                | 20c. Location - City or Town, State<br><b>7/11/2000 Sykesville, MD</b>                                                                                                                           |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400</b>                                                                                                                                                               |                                |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Myelodysplasia</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                            |                                                                                                                                                                                                                                                                                             |                                | Approximate Interval Between Onset and Death                                                                                                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pseudomonas sepsis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                             |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                             |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 28a. Date of Injury (Month, Day Year)<br><b>M</b>                                                                                                                                                                                                                                           |                                | 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No                                                                                                                                  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                |                                                                                                                                                                                                  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 29c. License number<br><b>RES-000</b>                                                                                                                                                                                                                                                       |                                | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>                                                                                                                                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Linan McClure, Sinai Hospital, 2401 W. Belvedere Ave, Balt., MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                |                                                                                                                                                                                                  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Patient known as Michael K Hamill

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 303A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

